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THE PERSON IN THE BODY

THE PERSON IN THE BODY

An Introduction to Psychosomatic Medicine

By

LELAND E. HINSIE, M.D.

*Professor of Psychiatry, College of Physicians and Surgeons,
Columbia University Assistant Director, New York
State Psychiatric Institute and Hospital*



91 ST MARTIN'S LANE,
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PREFACE

WITHIN recent years it has been generally recognized that a very fair proportion of bodily disturbances is due to the moods, the emotions of the individual, to the ideas he builds up about himself regarding his body. In some persons the fear of disease is often the only damaging evidence of disease, yet it can be so strong as to disable the person in all his daily activities. In this book special emphasis is laid upon the relationship between emotions and bodily ills, so that the reader may come to understand and to gain insight into one of the commonest causes of human disability. The combination of mental distress and its influences upon the organs of the body is what psychosomatic medicine deals with.

The author has covered all the usual, and some of the less common, disorders that have an especially significant association with the emotions. He discusses them from the standpoint of the patient and of the physician, since in no other department of medicine is it more essential that the patient know as much about the origin, development, and nature of his troubles than in psychosomatic medicine. Indeed, it is as important for the patient to understand his troubles as it is for the physician who treats him. This book is written for both, because each must know the part that distorted emotions play in sickness.

Case citations are liberally given to clarify the major issues of psychosomatic medicine. There is, for example, the account of the man who developed a severe stomach disorder when he could not reasonably solve the over-

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attachment he had to his mother. There are cases demonstrating the connection between an over-solicitous father and his daughter's complaints; others exemplifying physical disorders arising from unhappy marriages; still others relating to the failure to extricate oneself from the bonds of self-indulgence.

The author speaks frankly because he knows that evasions only serve to make a sickness worse by keeping the seeds of the trouble hidden. Nothing contributes more to the perpetuation of a psychosomatic illness than failure to get at its cause or causes. He hopes that this will be valuable to the patient, who has an interest in helping his physician to appreciate and treat the psychosomatic ailments from which he may be suffering, and will also enlighten any reader who wants to know the meaning of psychosomatic medicine in actual practice.

L. E. H.

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Nor so long ago a lawyer in his late thirties went to the consulting rooms of a psychiatrist because he was becoming more and more incapacitated by what he called stomach trouble. For some six months before he visited the psychiatrist he had come to the attention of several outstanding physicians who had examined him with great thoroughness, employing all the skills, clinical and laboratory, at their disposal. The reports were always the same, that he was in sound physical health and that he had "nothing to worry about." But he continued to grow worse; he lost a great deal of weight, could not sleep well, his appetite became meagre, and he lost interest in the members of his family.

He did have something to worry about. His illness was as real to him as it would have been had the physicians found that he had cancer or tuberculosis or suffered from some other direful condition. His sickness was real. It caused him to relinquish his legal practice; it kept him from his friends; it resulted in his giving up athletics and other forms of recreation; he lost the qualities of being a husband and a son. It was a grave illness he had, made worse by the reports of physicians that they could find nothing wrong with him.

People do not get sick when there is nothing wrong with them; they do not rebel against those who irk them with the retort, "You make me sick and tired,"

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without meaning or cause, even though it be obscure. The phrase "nothing wrong" should be dropped from the physicians' vocabulary, because it is obvious that people who are troubled do have something wrong with them.

About fifty years ago we began to depart from the doctrine that a sound mind is an invariable accompaniment of a sound body. Physical incapacity, it was learned, could come about as a consequence of the way a person felt in spirit, of the way he regarded himself, whether as a success or as a failure. Living is a series of trial and error, trial and success; when we find ourselves in an "impossible" situation in life, our predicament is often reflected in physical as well as in mental complaints. Unhappiness of mind is every bit as real in its effects as are the well-established organic diseases.

Our lawyer patient was a sick man, sicker, indeed, than he had been when years back he had pneumonia and his life hung in the balance. Now, with his stomach trouble, his living hung in the balance, for it appeared to him that he was destined to live "a living death." There is nothing more realistic, more agonizing, more disruptive than living without life. That is not a mere figure of speech; it is what our patients tell us when they are beset with symptoms to which the medical profession gives the verdict: "There is nothing wrong."

The stomach trouble of our patient was not stomach trouble. How often, in the absence of an adequate medical history, does a patient unwittingly fool himself and his doctor! Did he have stomach trouble? The whole history of the gastrointestinal tract was without any positive findings, save from the standpoint of

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normality. All laboratory results pointed to a healthy functioning of the stomach and intestines and their adjoining parts. It was the patient who made the diagnosis of stomach disease, and he deftly led the physicians to the same conclusion.

He complained of tension across the abdominal wall. That fact had to be established first, for the patient himself had thought from the start that his complaints were deeply seated in the abdominal cavity. Yet in common with other patients whose physical troubles stem from the mind, he did not really *think* where the trouble came from, he only *concluded*. He was greatly surprised when upon investigation he himself placed the complaints in the abdominal wall.

In enquiries into troubles of this kind it is not the physician who tells the patient where he feels sick; it is the patient himself who gives information leading to the part of the body affected. The skill of the physician lies in the rather simple though highly effective technique of getting the patient to give full and complete details of his complaints.

The patient was astonished to learn that he was not complaining of his stomach, though for the past six months he had no doubt about his "stomach" trouble. He was no less confounded to learn that it was not his entire abdomen but only a certain part of it that distressed him. Such patients, however, are almost always reluctant to give details. They are honest in the statement that they do not know the extent of the area involved in that it is part of their psychology not to know. They do not consciously withhold facts from themselves and others, yet, for reasons to be disclosed

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presently, they are unknowingly blinded from the truth.

Further enquiry revealed the fact that the area of which complaint was made was rectangular in shape, extending across the upper part of the abdomen about eight inches. It is surprising how difficult it is to get the patient to give an accurate account of the troubled area. It cannot be repeated too often that one of the most prominent skills of the psychiatrist rests in his ability to encourage the patient to tell a full story. It is one of the keystones to the successful treatment of psychosomatic disorders. It is so unlike the situation the physician finds when the disease is definitely organic that unless he knows of its existence he may fail to get at the real source of the patient's illness.

The "stomach" trouble had a linear dimension. Did it have breadth? "Never gave that any consideration," was the answer. He finally concluded that since the trouble was felt neither in the groin nor in the lower part of the abdomen nor in the middle part, it had to have breadth. How these patients arrive at positive findings by ruling out the negative ones! So often in his enquiries the physician must ask carefully about the parts of the body that are not causing trouble. What is left, oddly enough, is the ailing section. This patient was not an exception to the rule that the details of a psychosomatic illness are often difficult to elicit unless an appropriate method of approach is used. It was determined that the "stomach" trouble had length (about eight inches) and breadth (about one and a half inches).

It was further determined that the "stomach" had

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thickness. As the patient expressed it: "The whole thing is like a cylinder." Thus far he had described only its size and shape, something to which he had not given any thought prior to the searching investigation. Nor had the several physicians taken the opportunity to find out just what this "stomach" was. If they had, they surely would have known that in no respect was his complaint referable to the stomach.

This is one of the crucial distinctions in psychosomatic medicine. Too much emphasis cannot be placed upon it. The patient ascribes to some part of the body qualities in structure and function that have little or no correspondence to the known facts of anatomy and physiology. That is so because it is the "imagination," not the local anatomy, from which the troubles arise. The patient makes his body speak for his mind and in so doing he adopts as well as he knows how the language of organic illness. Psychosomatic language, however, is ordinarily the equivalent of a dialect; it is the idiom of a locality, as distinguished from the generally accepted literary language or speech of educated persons. Like the person who speaks a dialect, the psychosomatic patient knows nothing of the grammatical facts from which the dialect arises. He is concerned only with the idea of conveying a thought to himself or to others.

Our lawyer patient was as vague about the symptoms of his allegedly disturbed stomach as he was about the "stomach" itself. During the early efforts to arrive at a simple description of the symptoms, all he could say was that his stomach bothered him so severely that, in his words, "It makes my mind and body a blank. I feel as if I don't exist, yet I am in constant agony." To be

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sure, he was in a state of great anxiety. He was in a panic, as frightened as if he were about to meet some horrible fate. If the "stomach" trouble really represented disease of the stomach, he could never have travelled several hundred miles—and alone—to get to the psychiatrist's consulting rooms, especially since the illness had already been so distressing for six months. Nor could he have succeeded, as he so often did, in going to his office regularly each day, though in truth he accomplished very little there. Furthermore, at the height of his illness he resumed his favourite sport, swimming. If his stomach had been one-tenth as troublesome as he indicated it was, he would have been compelled to remain in bed.

How frequently does the physician see only the complaints of his patients! How often does he overlook many decisively important facts which the patient himself gives to him! A patient, complaining that he was about to die of a heart disease, was told to go home and rest. Apparently the many physicians he saw "sensed" that the ailment was not in the heart, yet they disregarded the fact that the patient was a helper on a lorry and therefore would be dead if the "disease" of the heart had even a remote correspondence with the intensity of the complaints.

Under careful examination of the symptoms of the lawyer patient it was first determined that the cylinder in the abdominal wall caused great anxiety when it became "extremely tense, as if it were going to blow up." After the rigidity had lasted many minutes there was a sudden collapse that "left me completely exhausted." He then said that during the first few months

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of his illness the same trouble was in the groin, not in the upper part of the abdominal wall. "I had to sit and hold it all the time in order to allay the wavy spasm. My mother's sickness is certainly not helping this any; in fact, it makes it worse."

With this amount of information about his psychosomatic disorder, information derived wholly from the patient himself as a consequence of his description, it was obvious that he did not have stomach trouble. Yet his mental blindness continued. He had absolutely no idea what it meant to have a rigid cylinder of tissue, first in the groin, then across the abdomen, a cylinder that grew and grew in tension until finally it exploded, leaving him completely exhausted.

During the first hours of examination he made occasional remarks about the great concern he had about his mother. He maintained that if he became so sick as to be unable to continue his law practice, he would be unable to continue to support his mother and she might soon die because of the absence of medical attention. In fact, when I first saw him he was humped over his office desk, the right hand pressed strongly against the "stomach" (the cylinder, as it later turned out to be), while he waved his left hand anxiously in the direction in which his mother lived, a block away from his office. He was in a state of genuine anxiety hysteria. He could not go to his mother because he felt so badly physically, nor could he stay away from her lest he condemn himself for being responsible for her death, if she died.

He and his mother had always been inseparable. She had tried to bind her other children to her, but

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they early recognized the dangers inherent in such total interdependence and they grew away from her. However, from his early childhood she found our patient most susceptible to her wiles. His brother and sisters competed with the mother to get him to grow wholesomely and naturally away from her, but they never succeeded. She reinforced the emotional bonds between them by recourse to alleged physical sicknesses, a condition that he repeatedly faced over the years and to which he became enslaved. It was not that he became a hypochondriac, but he suffered as much through her physical complaints as she did. He came to be an excellent image of his mother emotionally, while intellectually he pursued his legal studies with considerable acclaim.

As a wage-earner he soon superseded his father, so much so that his mother called him the father of the house. He very evidently displaced his father. He was proud of his new position in life, because one of the vows he had made to himself in childhood was that some day he would be influential enough to raise his mother's level above that provided by his father. There was other similar evidence to show clearly that he vied with his father for his mother's attention. He bought new furniture for the house. He took his mother to the better theatres. He drove her about in a better car.

He achieved the superiority toward which he strove. It was a costly distinction, however, because en route through early manhood he denied himself the wholesome companionship of other associates. He had many friends, but the friendships were based on intellectual affiliations. The older people who knew him called

him a model son; the younger ones shook their heads in half pity, for they knew that he never got close to anyone emotionally, save his mother.

The father put up no defence against the intrusion. Indeed, he was considerably relieved when the control of the household, the mother included, was taken over fully by the son. The father had often been chided by his wife for his poor showing as a breadwinner. Early in their married life he concluded that the marriage was a failure, that his wife married on the basis of convenience, not out of love. The children grew up in an atmosphere of parental coldness and they soon recognized that the mother was aggressively seeking an outlet through them, while the father retired into himself.

The patient grew restless as the years advanced. He passed the thirtieth year no farther away from his mother than he had been when he was ten years old. A successful lawyer, honest and ethical, but an unsuccessful human being—the idea came to him often, but he quickly put it out of his mind because it depressed him. His brother and sisters introduced him to eligible girls, but they were acceptable only to his intellect.

The disposition of his sexual impulses had bothered him from early adolescence. He ardently suppressed the practice of masturbation to the extent of inducing prolonged periods of abstinence and of impotence. Sexual troubles grew with the years, until finally he decided to break the most sacred vow of his life by marrying while his mother was living.

Courtship, begun when he was thirty-four years old, was turbulent. He was a fine type of fellow; his fiancée was a tolerant, motherly kind of girl, intellectually alert,

emotionally warm, and with a quiet determination to win over his mother. At times the rivalry, always present, became sharp. He was really squeezed between the two opposing forces. He actually felt that way and on occasion he mildly resented the position he occupied.

From the fiancée's point of view courtship consisted in her doing things in a better way than his mother did them. She had many advantages: she was neater and cleaner; she had better taste in dress and was an amateur interior decorator; she was more widely read, a feature to which he gave much attention; he did not give much weight at the time to her younger and firmer physique, because to him that was an asset to be used only after marriage. Indeed, the courtship, lasting over a year, settled into the question of which one could be the better mother to him in the succeeding years.

His mother had the position of superiority in the struggle, for she had bound him to herself for some thirty-four years and he had been a willing candidate to her overtures. It was not easy to tell whether the mother or the son had a priority in the matter of cementing the bonds between them.

It was unfortunate that sex cast the deciding vote, unfortunate because sex should not have been given the full responsibility for tearing a man—and tearing it was—from his long and hard-won past. Sex is important, but when a person gives it a decisive role in the determination of marriage and, as happened here, makes it a pivotal issue in the decision to break from the past, there is great likelihood that sex will crumble under the burden. It did in this instance, and as will be seen later the crumbling took the form of important and



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of the psychosomatic symptom described as "stomach" trouble.

The patient married when he was thirty-five years old. The girl became his wife on the grounds of her superiority in motherly qualities and of her availability as a sexual outlet. His mother exerted more pressure on him than she had before his marriage. He tried to wrest himself from mother and wife by delving heavily into professional matters. He became a financial success, as a result of which he moved to a residential part of the town far better than that to which he and his mother had been accustomed. She continued to remain in the old neighbourhood, a fact that alarmed the patient because he was afraid that something would happen to her and he would not be there promptly to look after her.

He visited her constantly. She telephoned to him many times a day, both at his office and home. The mother was steadily winning over the daughter-in-law. The latter assumed a still greater maternal role toward her husband than she had done previously. Her friends often remarked about it and encouraged her to be the bride that she was. She tried with much difficulty to set up activities that represented their true station in life, but she succeeded only in small ways.

The patient began to feel the effects of incessant worry. He accused himself of jilting his mother and of being unfair to his wife. He began to suffer from insomnia, loss of appetite, progressive inability to apply himself to his work, and restlessness. He felt physically and mentally fatigued and visited several physicians, each of whom concluded that there was "nothing

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wrong" with him. He was given sedatives to allay the insomnia.

What a poor remedy sedatives are for a life that is broken in spirit! Sedatives were the very things he should not have had, for they only served to drive him farther from a solution of his troubles. His wife had the best answer, though he refused to give it any consideration. She suggested that he was worrying himself sick over his new arrangements in living, that he should try to solve the mother and wife issues by facing them openly. He gestured her comments aside as being totally irrelevant. She warned him to "get it out of his system." Little did she know that she was expressing one of the fundamental remedies of psychosomatic medicine.

What do we mean when we tell a person to "get it out of his system," to "get it off his chest," to "get it out of his head," to "spit it out," to "spew it up," to "shake it off"?

What do we mean by "it"? The troubles we are in, or, more appropriately, the troubles that are in us. It is interesting to observe how even in our language we place the responsibility for our cares outside of ourselves. We are not in trouble; trouble is in us, at least from the psychosomatic point of view.

"It" was in his system. In the early phases of his dilemma he felt his anxieties in the form of mental and physical tension, from which he could not relax. He tried to shake it off by applying himself energetically to his daily professional tasks. Deeply rooted emotions, however, do not shake off, because they are a part of the tissues to which they are attached. Lady

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Macbeth never did succeed in washing out the "damned spot."

From the beginning of married life the patient was unable to consummate the sexual act with his wife. This deficiency began to cause great anxiety in him. He now had three major problems, that of mother, wife, and impotence. Since his wife was psychologically a substitute for his mother, in his own mind he had but two sources of anxiety—mother and impotence, or, if you will, mother surrogate and impotence. To the many manifestations of over-attachment to his mother, there now entered the question of sex. It must be understood that consciously he did not relate his sexual issues to his mother; nor did he believe over all the years that his relations with her were in any way unusual. He reasoned with ease that he was only doing what any other son would be expected to do.

The sexual impotence, however, occurred in a special group of circumstances. That fact has particular significance. It happened while he was in a gigantic struggle with his mother and her substitute. Should he go back to his mother or should he accept her in the guise of a wife? He could not turn to either. The facts of the case show that he was impotent in all respects to both women. He was too sick to visit his mother or to see that she had the simple comforts which he had previously provided. He was too sick to assume the role of husband even in the simplest household ways. Of all the forms that impotence took, the sexual one was most disturbing. He pitied his mother because he was neglecting her; he cried to his wife because he could not

be a husband. He was unconsciously enacting the negation of the Oedipus complex (see p. 111).

The Oedipus complex is one of the most powerful issues encountered in psychological medicine. It takes many forms of expression, but the general principle remains unchanged. It is a particularly common feature among schizophrenic patients in whom it is not infrequently openly dramatized. These patients harbour the delusion that they have killed the father, married the mother and have children by her. Like Oedipus they do not identify the mother as such. Many of these patients subsequently regard themselves as castrated.

What was the situation with our patient? To him the father was dead. Often he used that expression in describing him. But his mother was extremely close to him, so much so that she used to remark that her son was a better husband to her than her husband was. We know, too, that the son vowed that he would provide richly for his mother as an answer to her regrets that her husband was weak and wanting. For years, extending into middle life, he turned himself completely over to her, except in one respect, sexually. How can a man identify his interests almost exclusively with those of another person and at the same time reject the one remaining issue, especially when that one, sex, constitutes such a powerful drive? He cannot, save for brief intervals.

Our patient repressed the sexual issue for a time. It is not by chance that he repressed it while he was having such a terrific struggle with his mother. It is not fortuitous that he was impotent with the mother substitute, the wife.

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Nature abhors impotence, for it frustrates the racial instinct, one of the most powerful of all instincts. It is an odd facility of human nature that whenever an instinct is defeated in overt expression, some kind of substitute is found. A poor man imagines himself rich and in his delusions he counts his wealth. When a moron cannot accept his position in society, he may resort to the delusion of being a genius. An aged, decrepit man, who "has no sense, no sinew," flirts with adolescent girls. Nature never gives up. She endows the mind with the capacity to believe as implicitly in a delusion as in a fact.

There is a big distinction, however, between those who accept delusions and those who reject them. It is the conscious self, the ego, so to speak, that accepts or rejects. Generally speaking, psychosomatic patients will have nothing to do with the unrefined and immoral demands of the instincts. But when the instincts make crushing insistence upon recognition, the psychosomatic patient is compelled to accept a substitute. By and large psychosomatic medicine has to do with the translation of a mental conflict into physical terms. The phenomenon is technically known as conversion.

Our patient's ego was weakened because it was so thoroughly a part of his mother. In this impoverished state it fell easy prey to the immoral forces of the instincts, yet it was sufficiently strong to ward off any overt expression of them. For a long time it succeeded in denying completely, through sexual impotence, the instinct connected with the Oedipus complex. The denial could not be maintained, however, because with time, as the history showed, the ego grew weaker and

weaker, while the inimical drive from the instinctual sphere gained strength.

The patient was finally compelled to acknowledge the superiority of the inner drive, which he did by "accepting" it in the guise of an organic illness. It may be said that the instincts, too, had to compromise, which, it appears, they are ready to do when their functions cannot be fulfilled in the environment. The instincts are indestructible; man's conscious mind is fragile.

Now we may go back to the patient's psychosomatic complaint, the "stomach" trouble. On closer description it was seen to be a cylindrical object, tissue in nature, about eight inches long, located first in the groin, then in the upper abdominal wall. It got rigid and mobile, following which it exploded, leaving him exhausted. The patient himself recognized his "stomach" trouble as the male organ. As he said later: "I was weak down here (pointing to his sexual organs), but strong up here" (across the abdomen).

This patient's psychosomatic complaint, known as a conversion symptom, was a false conception, for which there was no corresponding reality. And so, too, was the impotence. He was both impotent and potent at the same time, a condition that is not at all uncommon with psychosomatic patients who experience a sexual conflict stemming from a parent. His abdominal symptom represented sexual potency, and the fact that he knew that his mother was in some way related to the symptom contributed to the anxiety he expressed. Of course, he had no idea whatsoever, before psychotherapy was instituted, what the abdominal symptom

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meant. He was spared such knowledge by at least three facts, namely, the overwhelming anxiety, the impotence and the belief that the trouble arose in his stomach.

The human mind is remarkably paradoxical in that it can create coexisting antithetic states. It empowers while it debilitates. A patient may lose all the facilities of normal adaptation, yet he may at the same time gain world-wide influence through fantasy. No human being even remotely approaches the universal power of the schizophrenic individual, yet the latter is in reality completely helpless. It is difficult for the beginner to appreciate the simultaneous existence of opposites and the great turmoil that it can bring to the conscious mind. The inner forces that control the psychosomatic patient destroy and preserve at the same time. They destroyed our patient by rendering him helpless; they preserved him by giving him more power—vicarious, to be sure, and troublesome—than he had ever had before.

It must be remembered that this is but a summary of a great number of facts constituting the patient's life. It does not represent the way the experiences and ideas were gathered from him. Nor does it indicate the technique of the psychotherapist. These questions are covered in detail in subsequent chapters, yet in order to give continuity to the present case, it is desirable to outline briefly some of the major principles involved in the understanding and treatment of the patient.

In the first place the psychotherapist should be an impartial accumulator of all the facts connected with the symptoms. He should have no preconceived notions as to what the psychosomatic symptom means, because

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if he does, he may soon learn that he is in error, and, furthermore, he may make the mistake of interrogating along the lines indicated by his preconceived ideas. Certainly the psychotherapist should not reveal to the patient what he thinks may be the mental meaning of the symptom. Often the beginner is greatly tempted to give a hint. Do not do it, for doing so may and frequently does hamper the course of treatment. It cannot be emphasized too strongly that successful therapy does not depend upon your insight into the hidden factors of the psychosomatic disorder, but it does hinge upon the understanding that the patient derives from the simple facts that he has given himself and you. As the psychotherapist you have the assignment to see that the patient arrives at a correct appreciation of the meaning. Unless you both see eye to eye the significance of the facts as they appear in everyday language, little can be expected in the matter of treatment.

For example, our lawyer patient, after describing his "stomach" symptoms at full length, came to the correct conclusion himself that the symptoms had no reference to his stomach. If he had been told that before all the facts were accumulated, he would not have accepted the opinion, or, having accepted it, the conviction would have been weak. Psychotherapy consists of a chain of circumstances. Obviously if the first link is not made fast, the remaining ones will not be.

Then, too, after the patient had described the "stomach" symptoms as consisting of an organic cylinder, eight inches long, in the groin, rigid and explosive, it would have been a major fault if the physician had been the first to express the idea that the

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symptoms stood for his sexual organ. It is so tempting to help a patient see what is so clear to us! But the help that we give him consists in recounting for his consideration the facts that he has given us. Enforced insight is not a therapeutic remedy. The physician had to wait several days before the patient suggested that an eight-inch cylindrical part of the body, attached to the groin, capable of rigidity and explosiveness, might be the male sexual organ. During the days of waiting, the patient's mind was honestly a blank. It meant that he was not psychologically, emotionally, prepared to see the meaning. The moral is to wait for the patient to be properly timed psychologically. Then the insight is true.

It does not always happen that the patient gives a continued and complete account of his symptoms. Ordinarily he interrupts the story of his symptoms with episodes of his life that are seemingly unconnected with the symptoms. It is highly desirable to let the patient do so, because, again in the interest of psychological preparedness, his way is usually the better. This does not hold true, of course, if the patient merely repeats and repeats his symptoms, without making any effort to describe all the facts associated with them, or if he constantly talks about subjects that are obviously unrelated to his troubles. His life experiences, those that have helped to determine the growth and course of his emotions, are never irrelevant to a psychosomatic issue.

When all the facts of the psychosomatic symptoms are gathered and edited, and their general meaning established, it is advisable to put them to one side until such time as the facts of the patient's past and present

life occurrences are likewise gathered and edited. This second phase of treatment comprises a history of the evolution and development of the emotional life of the patient, with particular reference to the facts of the experiences and not to the conclusions about them. It must be understood that treatment is based not only upon insight but also upon the gradual release of pent-up emotions. Psychotherapy is therapy of the emotions. Its objective is to free the emotions from their unwholesome attachments, and that can be accomplished only by freeing the actual events constituting the patient's life. This means that experiences and the emotions originally connected with them must come out simultaneously, and that the patient must understand the significance of the experiences. Unless these three requirements are met, it cannot be hoped to achieve the best results.

After our patient had covered all the items relating to his psychosomatic symptoms, he began to talk about himself. This is a difficult task for anyone to do. Usually the patient first reviews those features of his life that are less heavily connected with feelings, such as his scholastic activities, his general movements in life, his recreations, his ambitions, his professional achievements. As valuable as this information is in gaining a well-rounded picture of the patient, it is only preliminary to the delineation of him as a human being with a life history of emotional growth as a son, a playmate, a schoolmate, a lover, a suitor, a husband, a father.

Our patient gradually came to see himself in these various lights. He was the youngest of four children, the first two being girls, the third a boy. Their mother had

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early turned her affections away from her husband and toward the children, especially toward the boys. It was not long before the patient, as a boy, sensed the rivalry between his brother and himself. The competition for the mother's affections was more in his mind than in reality, because his brother soon turned away from the home for his pleasures. Thus the mother, starving for love, was unwittingly nourished almost exclusively by the one son, our patient. Moreover, she fed him emotionally as richly as he fed her. Save for the numerical presence of the six persons in the household, there were only two, mother and son, who were emotionally related.

Throughout the boy's early schooldays he diverted some of his deeper feelings to his teachers, but the transmission of emotions to them was short lived. On one occasion he fell "desperately in love, as much as a boy can," with a teacher, who, he realized years later during treatment, was the image of his mother. On another occasion he became extremely fond of a classmate's mother. It was evident that throughout his boyhood he lived emotionally for his mother.

He was a serious student throughout his adolescence, seldom going out with girls and then only in a purely social sort of way. He always asked himself: "How would mother want me to act in this situation?" He knew, because from his early years he listened attentively while she stressed the values of abstinence from almost everything except her and his career. His brother and sisters often tried to dissuade him from the kind of life he was leading, but their combined force was ineffectual. He used to go out with the boys, but

he soon learned how to manoeuvre away from girls with whom there was a probability of closeness.

The many facts of his life were reviewed extensively and they all pivoted around his mother. The disposition of his sexual impulses troubled him immensely. He remained abstinent. Over the years he simply refused to acknowledge that what later were seen to be the major impediments of his life—mother and sex—were anything but sound and normal.

It was clearly demonstrated by the facts that the girl he selected for a wife was chosen on the basis of her likeness to his mother. His marriage was but a physical, certainly not an emotional, separation from his mother. There is little wonder, therefore, that he was sexually impotent with his wife. And there is less wonder that he wished, underneath it all, to be potent. He achieved the potency, eight inches of it, with frequent ejaculations (explosions, as he called them), but he had to accept it, so to speak, in the hidden form of a psychosomatic illness.

The connection between mother, sex, and psychosomatic complaints should not be drawn or suggested until all the facts are organized in each of the three topics. One cannot be too conservative at this juncture of therapy. Establishing the interrelationship of the three is a delicate procedure. It is far better therapy to get the patient spontaneously to see the relevance of the three than it is to force him, however gently, to see it. It is more profitable to the patient if the psychotherapist assumes that the interdependence of the three is questionable. The final proof, moreover, rests in the disappearance of the symptoms and of the causes that are believed to be associated with their development.

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The symptoms did disappear in this case, disappeared gradually over a period of many weeks. With their removal sexual potency with the wife was established. It was reasonable to assume that the improvement had a direct connection with the unravelling of his difficulties.

It took a much longer time for the patient to free his emotions from his mother, or perhaps it is more appropriate to say to free the little boy in him from his adult self. He had really been a boy-man, neither a boy to his mother nor a man to his wife, yet both at the same time. That situation is not at all uncommon in psychosomatic patients. Indeed, it may be said that one of the functions of a psychosomatic illness is to enable a patient to retain the attachments of youth and of adulthood simultaneously, though the retention carries a penalty with it, ill health.

Over a period of approximately a year the patient's boyhood energies gradually, very gradually, shifted from his mother, and as they changed direction they were put into the service of mature activities. To designate this type of emotional evolution, the term sublimation is used. It means the reallocation of emotions from their infantile and childish modes of expression to those that are in keeping with the age of the individual.

Another point of importance, greater in some instances, lesser in others, is the treatment of those who have lived with an immature man for years and who therefore have had to adapt themselves to his immaturity. Perhaps it is not correct to imply that they are compelled to pamper the boyhood in him, because ordinarily they know full well that he is a boy and they accept him because he is.

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The mother of our patient realized that through treatment he was steadily becoming a man toward her. When she first recognized that she was losing her boy she made frantic efforts to keep him as he had always been. Fortunately, however, he was not dependent upon her for a livelihood. Had it been necessary for him to live with her or to be dependent upon her financially or socially, he might never have taken the attitude of an adult son toward a mother. The mother finally had to resign herself to her new son. She did so with a measure of equanimity, since he continued to be attentive to her, though now he was grown up.

There was always the question, too, of his wife. When she accepted him as a suitor, it meant she was giving him a trial period. Of course, he was doing the same thing. When they became engaged she knew well that he was a man who was established in practice, that he was honourable, reliable. She knew also that he was boyish and unduly attached to his mother. She was well aware of the competition she would have with his mother. In other words, she was pleased, as she herself put it, to accept the challenge as to which one would win. It was not by chance that she heartily accepted conflict with a mother over a man, for she sought marriage in order to escape from a domineering mother and father who thought that no man was good enough for her. She, too, like the man she married, had an overlarge element of childish dependence in her. She had to be watched, at least to see whether she had the capacity to grow up while her husband was so doing. Fortunately she had.

II

THE FORCE OF EMOTIONAL GROWTH

PSYCHOSOMATIC medicine is the architectonics of the human being. It recognizes that a multi-storied building, housing a single set of occupants, is structurally and functionally co-ordinated into a common whole. What happens at any given level may be felt throughout the building. If part of the footing gives way, all floors, including the top, get out of alignment and may be rendered unsafe. If an individual cannot control his instincts, then the cultural attributes that he so painstakingly erected are endangered. Many a fine superstructure, many a fine personality, suffers distortion because of an inferior basis. Or, considered from the functional side, the quiet members of the family who retired at a reasonable hour are kept awake and alarmed by the profligate son returning in the early hours of the morning with a riotous group of friends.

Our instincts are just that profligate. They do not care what the hour is, what the day is; they do not care what goes on above them. They care only for their selfish interests. As a rule unhappiness, up to the degree of a frank mental disorder, is a reflection of the alarming or destructive activity of the profligate son, who at times carries out his machinations in the basement (the source of the instincts) or on one of the upper floors.

It is the business of the psychosomatic therapist to know the structure and function of each floor of the building. He is the superintendent to whom the tenant

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refers his troubles. When the trouble is severe, he gets out the floor plans, studies them carefully, and then decides his next move.

The floor plan at which we are now looking is descriptive of the basement or, perhaps more correctly, of the sub-basement. It is the foundation of psychosomatic medicine.

Hereditary and genetic factors appear to exert influence upon the growth and mature appearance of the individual. A wealth of carefully conducted observations has accumulated over the years, much of it throwing light upon the original endowment with which the human being gets started in life. The many studies in these two branches make up what is called *constitutional medicine*, which occupies an important position in psychosomatics, more, however, at the present, from the investigative point of view than from the practical. We pass over this alluring field not because we fail to appreciate its great academic worth but because we must wait for its practical applications.

It is becoming increasingly evident that the mind has as rich an ancestry as the body has. The mind does not start *de novo* at birth, except from the standpoint of contact with the environment. The mind in its most pristine manifestations is already present and in operation at birth, constituting what is commonly known as the sphere of the instincts. The infant is a reproduction of phylogeny, that is, a reproduction of primitive man.

Habits, reflex in nature, are observable in intrauterine life. "From the standpoint of developmental psychology, the whole life cycle is a continuum, and the growth of

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the mind begins with the growth of individual behaviour.”¹ Rudimentary body reflexes appear two months after conception; mouth movements are observable in the third month. By the seventh month of intrauterine life “most of the vital reflexes necessary for extrauterine existence are well advanced. . . . There is good reason to believe that the infant of six to nine months, whether within or without the womb, is already a habit-forming creature, able to learn through processes of conditioning.”²

Sensorimotor development progresses in an orderly way: the hands close upon an object at about the eighteenth week after birth; by the twenty-fourth week the infant reaches for an object on sight; he can sit alone at nine months, walk alone at fifteen months, run at two years.

During the first few weeks after birth the infant is able to make mouth noises that are distinguishable as the cry of hunger or cold or discomfort. Pleasure is vocalized at about the third month, laughter at the fourth, eagerness at the fifth, syllables at the ninth, response to words spoken to him at about the tenth month. The expression of emotions is well under way in the early months of life, and in so far as can be determined they are almost exclusively conveyed along physical channels. Words gradually acquire significance as the medium for the emotions. At the end of the first year the child has a vocabulary of a few words; at the end of the second year it consists of about three hundred words; by the sixth year it has increased to about three

¹ A. Gessell, *Encyclopædia Britannica*, 14th ed, vol V, p. 468.

² *Ibid.*

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thousand words; at the twelfth year the vocabulary approximates fourteen thousand words.

This enormous quantity of words is a reflection in part of the development of the psyche or mind, though it is also related to intelligence as a brain function. It does not seem wise to draw any sharp distinction between the two in their earliest phases of development. Indeed, the mind and the body undergo differentiation very slowly. The point that we stress at the moment, because of its relevance to psychosomatic matters, is the steady distribution of energy to the growing body and mind. The newborn infant, by comparison with him at later periods of growth, is vegetative and unorganized. During the early months and years he acquires a rich life of organic existence, the "memories" of which are so closely identified with tissue that they are called organic memories; as such they may continue to exert their influence throughout life, though they are never, save in rare instances, recallable as memory; they are felt, perhaps very strongly as they are in certain abnormal mental states, though they are not recognizable to the individual as phenomena of past experiences.

The hypochondriac, that is, the person whose life is essentially bound up in his organs, the one who manœuvres himself in life to the advantage of his allegedly sick organs, is not at all unlike the infant whose earliest training and experiences are embodied, not "emminded."

The vegetative phase of infancy, slowly but never entirely, gives way to the environmental phase. Evidences of the personality begin to appear. The frame-

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work of the "individual" is laid down—it appears most likely—long before the framework is filled in by experiences, at least of the extrauterine type. The basic responses of the infant, his attitude toward those about him, his predispositions, are recognizable and describable for some time before experiences with the outside world begin to define or give special cast to the personality.

The structure of the personality is first played upon by intrinsic factors made up of organic cravings and impulses, such as hunger, thirst, defecation, sleep, love, hate, imitative activity, curiosity, and so on. Some of these internal stimuli are clearly organic in nature, others have the essence of personality, so to say, though each is closely allied with a vegetative type of existence. The science of infancy is not sufficiently advanced to allow any sharp distinction to be made between the mind and the body during the early months, perhaps for a year or more. It is a well-known fact, however, that bodily energy expresses itself in ways that we are accustomed to speak of as emotions. The infant laughs, cries, shows resentment, registers dissatisfaction, indeed he runs the gamut of emotional activities before the outside world has exerted its pressure upon him.

For purposes of description words have been coined to designate the "source" of these emotionally toned activities. The word most commonly used by psychiatrists today to refer to the original sphere of instinctual activity is *id*, meaning the "it," the reservoir of psychic energy, containing all phylogenetic mental acquisitions and their instinctual components. The *id* is a hypothetical zone, deeply embedded in tissue but in later

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development extending beyond tissue, at least in its functional manifestations. Comparatively little is known of the exact relationships between the id and the soma (tissue); its anatomy, physiology, and pathology are known more by inference than by exactitude, yet without such an assumption the practical applications of psychosomatic medicine would lose much of their value.

The current keynote is the inseparability during early infancy of the psyche and the soma. The one looks like the other; the one has many characteristics of the other. It is at this stage of development that the foundation for psychosomatic medicine is laid; upon this, successive floors are erected, floors that make up the building that we call personality.

Among the intrinsic psychosomatic factors that often give rise to troubles later in life are those associated with three principal bodily zones—oral, anal, and genital. Usually the average individual is not at all troubled with the oral and anal zones as such, for nature fortunately offers sublimated forms of outlet for them. It is only when the personality breaks down severely, as in the psychoses, that there is a reappearance in consciousness of oral and anal factors, sometimes in their original infantile manners of expression. When the personality is so disrupted, it becomes the problem of the psychiatrist with special training. Since the contents of this book are directed toward the non-specialist in psychiatry, this otherwise very important topic of oral and anal interests will be passed over with little further comment.

There is an admixture of energy in both the oral and

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the anal zones; one quantity is given over to organo-physiology, while another quantity goes into the service of psychophysiology. This is to say, a certain quantum of energy appears at these body areas as emotional components, while the remainder has the function of keeping the tissues running. In the normal, healthy infant there is a relative diminution of both energies as the months and years pass. In the early months the infant is largely his alimentary tract, with special accentuation at the oral and anal ends. Later, with the development of locomotion, there is a redistribution of energies, a large part appearing in connection with muscular and associated visceral activities. Whether it is correct to speak of a redistribution is not established, although practically such a concept is valuable. It is at least correct to say that oral and anal activities gain a relatively less important position in the over-all activity of infants.

Some of the energy formerly spread throughout the alimentary canal begins to appear at the genital zone. By the time the infancy period is closed (at about the fifth year) a very fair amount of energy has invested the genitalia. Nature vitalizes this zone as it does other parts of the body—eyes, ears, nose, skin, muscles, viscera, psyche, and so on. Our culture, however, draws special attention to the genital area by the taboos it places upon it. Nature reinforces the attention by endowing the zone with pleasurable sensations.

We encourage the infant to use his eyes, ears, mouth, hands, feet—everything, in fact, except his genitals, except for purely urinary behaviour. He is regimented daily in the use of his body (except the genitals) and is

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rewarded for good activities. The use of the hands is praised, save when they go to the forbidden area. This very compelling intrinsic impulse must be held in abeyance. It is not to be wondered at that the zone acquires special distinction.

If we were to shut off a child's sight for his first five years, let us say, it seems certain that he would tug and pull at and be harassed by the blindfold. He would long for the light of day. If he were deafened by forces about him, a conflict would ensue. In other words, sex gains importance from two sources, first from nature, second from nurture. This is not to say that sexual functions should be given equal privileges with vision or hearing; it is to say that the energies of sex should be judiciously, not harmfully, diverted to other acceptable channels of expression.

The unwholesome condemnation of sexual interests in infants often leaves a psychic scar that is difficult to remove, except through special psychotherapeutic procedures. The parent who vehemently condemns usually is the one who does not provide the proper diversion from the genital area, namely, healthy love and affection in many other ways. Prudent love is the best safeguard for the sexuality of infancy. It allows energies to infiltrate the sexual zone and to be drawn off through tender, non-sexual channels. It is a severe trauma to a child to block the energies from the area. Nature imposes a heavy penalty for the closure or stoppage.

Nature likewise enacts a heavy fine for the precocious display of sexual energy and is aided by an additional fine from society. Either extreme—stoppage or freedom—is fraught with danger to the personality.

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We have gone a little beyond the theme of this chapter in order to clinch the proposition that in the early phases of infancy the problems of growth and development are pre-eminently psychosomatic. We have seen the influence thus far of the intrinsic factors, that is, those that are derived from inherent properties of the body. Emphasis has been placed upon this phase of growth because it is essential to subsequent phases of development and because the seeds sown in this period often condition the future life of the child.

More benefit will result from the wide dissemination of the doctrines of mental hygiene than from treatment of the ill effects of bad upbringing. It is wiser, for instance, to prevent diphtheria than to cure it.

Prevention is all the more desirable for the reason that very few people can remember enough of their first five years to ensure good results from psychotherapy. Even those with a phenomenal memory for their past can rarely reproduce in memory the very early experiences and impressions that are "imprinted" on the mind as "organic memories." Thus psychotherapy today fails to touch directly the most powerful epoch of our lives. To put it that way is to be somewhat academic, because from the practical point of view we can reach back far enough in most instances to remove deleterious influences.

Normally, infantile modes of behaviour and thinking are abandoned in favour of conduct appropriate for the next phase of growth. This abandonment consists in repressing infantile tendencies into that part of the mind called the unconscious. According to the most workable theories today, namely, those of Freud, under

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normal conditions of growth most of the energies of infantile impulses are withdrawn from the activities of infancy and put into the service of activities of the next period of growth, called the latent period.

A large number of individuals, however, fail to complete infancy at the fifth year. These are the children who carry the bulk of infantile reactions along for an indefinite number of years. A few, some 5 to 6 per cent, such as those who succumb to a psychosis, are incapable of transferring their energies to integrated behaviour in a manner to keep them well sustained in the environment. They are perpetual children, whose psychosomatic ways of adaptation are more or less exact replicas of the ways of their infancy.

There is a second large group of persons who prolong the basic reactions of infancy throughout the latent period (extending from infancy to puberty). At or about puberty they begin to socialize themselves as they should have done at the termination of the infantile period, and they succeed to a certain extent. But they compromise. They accept the new, providing they can retain the old. They are never happy with either. They are overgrown children, children who have matured physically and intellectually but whose lives are essentially anchored to emotional infancy. These persons make up that large group known as psychoneurotics, almost all of whom have a prominent psychosomatic facet to their personality.

The important fact here lies in the consideration that *emotional infancy is largely psychosomatic infancy*. Almost every psychoneurotic will present to the physician in entirety a particularly important set of physical

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symptoms, while unwittingly withholding his infantile attitude toward himself and others. It is actually the concentration of one's interests or energies upon a given organ, making it appear to the uninformed that the organ is physically out of order. Every adult protests vehemently against being a baby, but very few adults, notably psychoneurotics, object to the dependent, inferior role occasioned by what they do not know to be an "alleged" physical sickness. It is true that the feeling of illness, whether mentally or physically determined, is incapacitating to a greater or lesser extent. To dub it "imaginary" is to designate its cause, but in no wise does it alleviate the effects, save for short periods.

The psychoneuroses constitute about one-third of all the problems seen in the practice of medicine. But it is not the psychic aspect that is ordinarily presented to the physician. It is the physical. Human beings have had centuries of training in ways of concealing disorders of the personality. It is done through what we now know to be the simple expedience of shifting the attention to physical structures. This practice is steadily losing favour because the "trickery" is being exposed.

A third group of patients comprises those who because of a pathologic physiology—at least that is the current way of viewing it—are incapable of sound mental and physical adaptation. These persons really have a disordered physiology, usually in the realm of the autonomic nervous system and its many organic associations. Some of these individuals with a mild disorder are not affected mentally to any appreciable extent; others, with an equally mild disorder, show

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more or less pronounced mental instability. The difference probably rests in the strength of the personality, other things being equal. This is a genuine psychosomatic state, requiring psychotherapy and organotherapy.

A fourth group of patients is made up of those who have unquestioned organic pathology. Many such patients are not abnormally distraught under the circumstances; they are mentally ill at ease, often very much so, but it is reasonable that they should be disturbed. Their mental equilibrium is re-established when the bodily function is harmoniously restored. Psychotherapy is not called for in the management of these cases, though an honest evaluation of all factors involved is greatly to be desired. Sometimes this is called assurance therapy, which is little more than an honest review with the patient of the cause and probable outcome of his disease.

A subdivision of the fourth group comprises those patients with definite organic pathology whose personality equipment is so fragile and weak that it breaks under the strain of the physical disease. In these instances genuine psychotherapy must supplement organic treatment, because if that is not done there is always the grave possibility that the mental disorder may long outlast the physical.

III

THE ROOTS OF PSYCHOSOMATIC MEDICINE

BECAUSE the mind does not have a circumscribed localization in the body—at least it is not known that it does—it is difficult for many people to understand it as an aggregate of functions that are conveyed from the brain to various parts of the body, thence to the environment. It will represent an incalculable advance into the science of the human being when and if the mind can be depicted materialistically, as can, for instance, the heart, lungs, and intestinal tract. Then the interrelationship between, let us say, anxiety over the loss of a loved one and changes in body physiology will undoubtedly be better appreciated.

The situation today in the field of mental medicine may be viewed from two different angles, each of which, however, converges upon the same object, man. From the one vantage point, active research is going on with the idea of determining what influences the mind can bring to bear upon the body. Can grief so alter the organic physiology of the body that disease may be the consequence? Can a stomach ulcer come about as a result of persistent tensions due to frustrations in life? Or must other factors be present in the stomach wall, such as constitutional deficiencies or alterations in the acidity or bacteria, before emotional tensions can play a part in the production of an ulcer? We are in the midst of investigations from both points of view, the organic and the psychological, and it would there-

fore seem to be the better judgment to reserve decision until the facts from each side are more convincing. It would appear, however, that many biological disorders may be a consequence of the combined action of mental and physical elements and that it is no longer tenable in the description of an ailment to refer to the causes as either mental or physical.

Capable research from the mental point of view has thus far given us an excellent description of the organization of the mind from the *functional* standpoint. Almost complete credit for this goes to Sigmund Freud, whose masterful observations gave us a practical, working plan by which mental reactions can be examined and treated. He traced the origin of the instincts back to, but not into, brain structure. It was a huge task for any one man to take up the study of the instinctual components from the time they first seemed to emerge from tissue and to acquire sufficient distinction to be followed through their subsequent manifestations. Freud pursued scientific procedures that are so commonly observed in other departments of medical research. For example, diabetes was first described from the standpoint of the symptoms it produced in the patient. Observations were then made on the physical changes induced by alterations in sugar metabolism. The studies led to research of the many organs of the body involved in the manufacture and distribution of sugar, culminating in the present treatment by insulin and other products.

It is a well-established fact that sugar taken into the body is subjected to many biochemical relationships connected with various organs of the system. Sugar

thus combines with the chemistry of the organ in which it appears and in so doing it takes on new properties and new functions, all of which are studied under the heading of sugar chemistry from the viewpoint of the particular organ under investigation.

The general principles of research carried on by Freud were not different from those conducted with respect to specific organic elements. Freud, however, had to work with the instincts and with their multiple representations in the body. As a starting-point for study he had the great task of separating the instinctual reactions from the organs in which they were found. The separation was artificial and was done solely for the purpose of making the instincts available for isolated study. That is exactly the procedure carried on by research workers in other fields of medical research. Sugar does not exist in the body as it does on the dinner table. Its chemistry is a combination of sugar with the special properties of the organ with which it unites. So, too, instincts never appear in pure form as isolated entities. As understood today, they are always in intimate relationship with tissue; indeed, it seems to be a fact that an instinct cannot be expressed save through some organ of the body. Love and hate, for instance, are not known to have manifestations other than through the medium of body material.

Freud separated the instincts from the body for the purposes of study, though he never lost sight of the fact that they exist naturally within it. Psychoanalysis is, and always has been, a psychophysical field of investigation and treatment. We must accept, however, as a working hypothesis, the idea that instincts and their

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manifestations cannot yet be studied by materialistic instruments of precision. New standards of measurements have had to be constructed and used, taking human behaviour as the material for measurements.

Freud saw, as all of us see, that the relations of a mother to a son or a daughter or a husband or her own parents are highly significant to the ways by which she gets along in life, and considerably important to her state of health, mental and physical. Her moods are imbedded in her postures, gestures, ideas, in her appetite, digestion, heart action, respiration, and so on. How to separate those moods for study and treatment was the difficult assignment that Freud imposed upon himself. New words and new concepts had to be devised, because the old ones were not applicable.

Before describing the organization of the mind from the Freudian point of view, it is desirable to emphasize two special viewpoints. In the first place, the state of our present knowledge enables us to define the mind from the functional standpoint only. This is an odd situation in medicine, yet it is unavoidable: it is as though we understood the purposes and results of heart activity without knowledge of the heart itself. We are unfamiliar with the specific starting-point of instinctual reactions.

The second point of emphasis is connected with the first. The nearer we get to that zone of biology in which instincts and body tissue appear to be inseparable the more uncertain are we of present concepts relating to that zone. But as we move along the pathways of childhood, adolescence, and maturity emotional reactions are more clearly distinguishable from the body organs

through which they are conveyed to us for study and treatment. From the practical viewpoint, therefore, greater stress will be placed upon the instinctual and emotional life of the psychosomatic patient from about the fourth or fifth year on to adulthood. There is ample material in that span of life that is amenable to our treatment procedures.

For general practical purposes the mind may be divided into two great sectors, called the conscious and the unconscious. The centre of the conscious realm is the ego or the perceptive self, whose function it is to act as arbiter, so to speak, between the demands of reality and those of the unconscious sphere. Past and present experiences may reside in the conscious area, with or without the patient—or better, his ego—evaluating them correctly.

The unconscious part of the mind has two general subdivisions. The one, nearer consciousness, is made up largely of past personal experiences that were relegated to that area either because they are useless for current needs or because they are unwanted for emotional reasons. It is known as the *personal unconscious*.

The second division of the unconscious contains the unmodified and crude instincts, or *racial unconscious*. In close contact with its neighbour, the racial unconscious is made up of instinctual components, many of which cannot be differentiated from the organic tissue from which they apparently issue.

It is highly important to know that while the mind in each of its stratifications is a continuous process, there are two major factors that determine whether a psychosomatic illness has a mild or a grave bearing. One of

them is the nature and source of the agent causing the trouble; the other is the relative strength of the part of the mind upon which the causative factor is acting. In what follows, an attempt will be made to give clinical credibility to these concepts.

It seems to be true that the success of treatment measures is more or less directly proportional to the distance that the causative factors are from the infancy of the patient. Psychosomatic illnesses that are set in action principally as a consequence of external forces in an adult who has shown good adjustment over the years respond favourably as a rule when the outer forces are removed. These constitute the relatively simple cases in which anxiety and its attendant physical symptoms form the core of the disorder. In them the basic soundness of the mind is essentially unaltered, because the threat to the individual is not felt beyond or much beyond the conscious ego. It is said that these patients have an *ego neurosis*.

A twenty-nine-year old man complained of generalized fatigue and palpitation of the heart. He said, too, that his mind "went round in circles." His physical troubles came upon him very gradually, starting some two years before he was examined psychiatrically. All physical tests showed him to be in excellent organic health. Intellectually he was well endowed, having an intelligence quotient of 142.

He was the older of two boys in a family that provided extravagantly for them in their youth and later. He passed through infancy and childhood in a natural way. It was noticed that when his brother was born the patient was disappointed and seemed to feel that

all was lost. The parents at the time regarded it as a transitory mood that would disappear when he realized that the coming of the brother did not mean that he was never more to get any affection. They thought it was simply "a case of injured pride," which is in a way another name for an ego neurosis.

The general tendency to feel hurt when he could not compete with his brother and others continued throughout his childhood. His interests seemed wholesome enough; he liked to play with others; he shared his toys; he was a good sport; he was kind and courteous to others. But when he lost in competition he shook his head in despair, while quick to commend his opponent.

He made good progress through school, yet again in scholarship as in play he succumbed easily to his superiors. His parents observed that throughout his high-school days he was a steady and capable scholar, but he surrendered too easily to his betters. An inventory of his characteristics revealed that in all other respects he was making excellent progress. He was an outgoing young man, articulate, friendly, genial, with a variety of friends and associates. But his pride, so to speak, was fragile. The old tendency to feel hurt easily seemed not to improve as he gained strength of character. Indeed, at the time of his graduation from high school his tendency to feel hurt seemed to have been accentuated. His parents and friends sensed that he had a "what's the use?" philosophy, though he appeared not to be depressed and he kept trying to go forward. He was a jocular fellow, sometimes happy-go-lucky, even being the life of the party on occasion.

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Still, it was felt, and he later verified the feeling, that he was play-acting.

His brother was meanwhile advancing in good stride with plenty of strength in mind and body. He knew what he wanted to do in life and he did it. His sense of sureness only served to make the patient's feeling of insecurity stand out more prominently to him.

The patient was learning the value of good humour; people liked him for it. Here was something that buttressed his ego and he capitalized on it. What he failed to see, however, was that he was trying to make humour carry him through almost all situations in life. It is true that it stood him in excellent stead when he entered college, but as he later put it, his instructors graded him on the basis of scholastic results and within two years he was so hopelessly behind that he had to change colleges. Even in his subsequent illness, while being treated, jocularly and saddened uncertainty formed an odd partnership.

His father was growing old and he hoped that the older boy would learn the business and take it over. The younger brother had steadfastly refused to have anything to do with the business. He intended to be a professional man and he became one. Just before he graduated, the father died, leaving the business to the sons but under the management of a very capable man. The elder son, afraid to take responsibility, was considerably perturbed over the prospects of having to move into the business. He tried to enlist the interest of the brother, who would not even discuss matters relating to the firm. The situation was made worse

when it was discovered that the manager, fully efficient while under the direction of the father, was as difficult about making decisions on his own responsibility as was the new part owner.

The young man leaned upon the manager as he had upon his father, although neither was able to support the other. His sense of humour rescued him momentarily from difficult situations, to the intense discomfort of the manager, who kept trying to maintain his role as a subordinate. Each was attempting to get underneath the other. The patient grimly laughed; the manager grew scared. The situation became pitiful.

Growing weaker and weaker, the son began to acquire physical complaints in the form of fatigue, rapid heart beat, and confusion. He took his physical problems to many doctors, each of whom found "nothing wrong." Then, unfortunately, one of the physicians advised the patient to marry. Although the physician must have known intuitively the general nature of the patient's disorder, he did not prescribe the correct course of treatment for it.

The patient married, though he knew at the time that he did not love the girl. As he said, he was resigned to live a life of errors, but he was also prepared "to put on a show of affection" for his wife's sake. He thought it was a shame that she was being sacrificed to his inferiorities. He sincerely felt that he was unfair.

His confusion grew worse. He became so fatigued, as well as troubled about his heart, that he decided to get away from everything that called for responsibility. Without letting anyone know, he travelled

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some two thousand miles to the psychiatrist, a long distance under trying circumstances for a heart case—which he was not.

The details of his life are many, but it may be said by way of summary that his psychosomatic complaints were largely a result of a troubled conscience of which he was at all times aware. He did not, however, draw any connection between conscience and his physical complaints, though when the association was established he was quick to see it.

This was a relatively simple case to understand, though it was by no means easy to effect a rearrangement of his philosophy of living to the point at which he began to strengthen his conscious mind and accept responsibility. He had many assets, which were gradually put to substantial use. He found great consolation, when his inner or unconscious or instinctual life was reviewed with him, in the knowledge that it had not been primarily disturbed by all the vicissitudes through which he had passed. Underneath, he was a sound man. That is why treatment from the ego level, so to say, was sufficient and effectual. He had an ego neurosis that had spread to the body, causing him to suffer from physical complaints.

The foregoing is an example of the type of mental illness whose causes lie in the conscious part of the mind and remain there. From a purely academic point of view the psychiatrist could have psychoanalysed the patient to the lowest reaches of the unconscious, but experience shows that in cases of this kind such deep psychotherapy is unnecessary. The patient has been back at work and back in home and community life

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for over a year now, without any psychosomatic complaints and with a zest to make good.

A second type of psychosomatic illness is seen in those patients whose conscious ways of living are causing them much trouble, though they see nothing unusual at all about their character traits. They are the people who, upon looking themselves over, are satisfied that they are sound and reasonable, although it may be very evident to others that their character traits are putting and keeping them in distress. They have what is technically known as a *character neurosis*, which may become sufficiently severe to overflow into body organs, causing a psychosomatic illness. While it is true that the original trouble is an outgrowth of deep-lying factors in the realm of the unconscious, it seems also to be true that treatment of the elements of the conscious part of the mind often suffices to remove symptoms and to effect a reasonable modification of the character anomalies.

A young lady, twenty-three years old, had been thoroughly examined by several nose specialists for a chronic "running" nose. Throughout the day for approximately a year she blew her nose vigorously about every ten minutes, each blowing taking about a minute. She was always careful to apologize for the act by explaining she was sorry to be such a nuisance to others. Ordinarily no one seemed to be bothered by the habit, perhaps because she did not stay with one person long enough to have him or her show disfavour. Still the idea that she was a nuisance to others persisted.

It appeared quite incongruous to see a young, healthy, smiling girl, otherwise full of energy, suddenly give

intense and serious attention to her nose, as if it were paining her. It did not matter where she was—at a dinner, a play, a dance, a tea, or sitting quietly with a suitor—attention would be abruptly withdrawn from the immediate circumstances in favour of energetic nose blowing.

She was a refined, well-bred, intelligent, companionable girl. She had successfully met the many situations she faced in growing up, that is, all except one, which she kept entirely to herself, so she thought. She realized for years that she was afraid to fall in love, because, as she also recognized, she never felt completely a girl. She knew that from the physical standpoint she was female; she always dressed attractively, used cosmetics and perfume, was flirtatious and agog over attention given her by men, yet little ever took place between her and an eligible young man except repartee. She had several suitors, one for as long as two years, the relationship with whom was maintained by her on the so-called platonic level. The boy knew what it involved to be her companion, and although he had additional interests, he never got around to expressing them. She explained that he did not dare to do so because he tacitly understood from the beginning of their friendship that she dictated the course of their activities.

Beneath the façade of amicability and leadership she knew that she had a pronounced envy of men. It saddened her at times to realize that she was a pretender to friendship, that the breadth of her intelligence was a barrier to the things she really wanted in life. She even hated learning, but she was schooled in it as far back as she could remember.

She was unhappily familiar with her father's philosophy, that the only good progress in the world was made by men. He repeated that so frequently to her that it occupied a front position in her mind over all the years. He regretted, so he told her, that she was a girl, because he had wanted to train a son from his earliest years to contribute intellectually to the world, as he had always done. He conceded, however, that he would be able to make her an exception to the rule, because he had unlimited stoicism, and, since she was his image, he did not expect to fail in his efforts.

She was his image by implantation, not by nature. And as she grew up she was further cautioned by the father to limit her affiliations with people to intellectual exchanges. However, her femininity was never obscured to the extent that she was not aware of it, often acutely. That was true until about her twentieth year. The fact that she was suppressed, not repressed, until that period of her growth was a matter of considerable weight from the standpoint of probable outcome under treatment. Suppression means an active and conscious holding back of impulses and carried with it a favourable outlook under a milder form of therapy. Repression, on the other hand, implies a forceful retention of the impulses in the unconscious sphere by forces in that area. The nature of the impulses is unknown to the patient, who struggles, therefore, against unfamiliar forces.

At about her twentieth year the girl began to feel that she had gained sufficient intellectual strength to master her surroundings. Her father felt that way, too, and arranged to put her in a position of authority in

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his office. She was afraid to tell him that she really was not inclined toward such a life. A veiled reference to that effect now and then was quickly waved aside. At the same time, she thought that she was prepared at last to be what her father wanted her to be. Confusion resulted, and when it had cleared she was on the way to a man's career.

During the next two years she developed an executive attitude, or, better, the executive attitude of her father. The impulse to be a woman suffered almost complete repression, though there were outward semblances of femininity in dress and extraoffice behaviour. Fortunately, however, the "execution" did not become ingrained in her; that is, it did not infiltrate her whole mind. It existed only in the form of an impenetrable barrier that served as an excellent aid to the unconscious forces that were holding femininity in abeyance.

She was steadily meeting the world in terms of her executive self. She came to believe implicitly in her new role. This is the condition referred to when it was mentioned that certain patients develop character traits that may be obnoxious to others but into which they have no insight or which they defend as correct. She acquired a character neurosis and was going along with outward equanimity. Inside her, however, the rejected femininity was not remaining idle. It could not break into consciousness as such, but, as happens with so many other heavily repressed individuals, it finally appeared as a psychosomatic symptom, the ever-running nose.

It must sound strange to the beginner to hear it said that a running nose is, under given conditions, the

equivalent of genital excitation. It appears more than strange. It is ludicrous. How can anyone come to such a correlation? Here is a summary of the facts, essentially unsolicited, except in so far as the necessity of history taking dictated.

The patient smilingly said that it was embarrassing to have others see mucus running from her, but there was nothing she could do about it. Physicians had given her all kinds of treatment; they had worked over her nose endlessly, so it seemed to her, inspecting it, handling it, inserting instruments, injecting all sorts of preparations --without avail. In her own description, she was "wet most of the time" and likened her condition to leaking. She had not leaked so much, she humorously remarked, since she was a child, when she used to compete with girls in the matter of urinating for distance. She cautioned the psychiatrist not to draw any connection between the two conditions. He responded by repeating that he wished to have a full and complete history of her troubles.

It was ascertained from her that the nasal fluid was warm and that her nose was warmer, because of the incessant blowing, than it ever used to be. For a long time, she said, she was so nose conscious that she often blushed and, when she did, she took pains to explain that her bothersome nose made her do so. The history taker did not ask her why she felt the urge to explain what seemed so obvious to others. It was evident that she "protested" too much.

She went on to say that she finally got accustomed to the nose, that she would not have continued going to physicians if it were not for the fact that it was

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keeping her from her friends, making her asocial. "I guess I'm more sensitive about this with boy friends; now don't tell me it's sex. If you did, I don't know how surprised I should be. Isn't it awful," she asked smilingly, "to show your sex so openly?" She continued with her story without essential interruptions.

Over several history-taking periods she gave many details of her life, the summary of which has just been given. She told of her struggles to maintain femininity in the face of strong opposition from her father. As the story unfolded she made her nose an intimate part of her efforts to gain the position in society for which she yearned. She realized that she was giving the nose great importance as a social asset, "and liability, I might add." She even went so far as spontaneously to say that she had used her nose as other girls used sex.

Intellectual insight was the first step in the disappearance of her nasal symptoms. Like so many other patients with a similar problem she was unprepared psychologically to relinquish the symptoms until she began to shed the role of executive in favour of being a girl. While she was in the process of assuming the psychology of her sex, she became enamoured of a young man, who unwittingly facilitated her recovery. Gradually she acquired what may be called emotional insight; that is, she felt the validity of the relation of the nose to her psychological troubles. The nasal symptoms disappeared entirely.

As she continued to improve she became engaged, but the date of marriage was put far enough in the future to make reasonably certain that recovery would last. They married about a year after treatment was

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over, and now for the past two years she has been not only without psychosomatic symptoms but, of greater importance, she is a woman.

It is well to remember several significant points about this patient. First, evidence pointed to the assumption that she was born a female and that in her very early childhood she acted like one. Second, her emphasis on male psychology was not derived from her inner self but was imposed from without. The difficult patients to treat are those who without encouragement grow in the direction of the sex to which their anatomy does not correspond. Third, she resented, though quietly, the role into which she was forced; she resented it, furthermore, until she was well into adolescence, that is, until she was beyond the age when the deeper structures of the mind suffer greatest damage. Fourth, character traits did not crystallize into a neurotic pattern until she passed the middle period of adolescence. This does not mean that she was not at the periphery of a neurosis from early girlhood, because she was. She could have been spared the neurosis had she had mental-hygiene treatment much earlier in life. Fifth, the psychosomatic complaints did not appear until her twenty-second year. Sixth, it was a considerable aid to treatment that she sincerely desired that the symptoms be removed and her ways of living changed. Seventh, *she was psychologically ready for a change.* This is *one of the most significant guides to the probable outcome of a psychosomatic condition.* Without it the best application of psychotherapy may be totally ineffectual or only partially effectual. Sometimes the treatment does not begin to take hold until the patient is far into the

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analysis. Then patience and frequent review of experiences are necessary. (It should be known that the average psychosomatic patient may be as reluctant to give up the neurosis as she was to go into it.)

Thus far we have indicated the factors involved in the evolution of psychosomatic states that arise principally from the conscious part of the mind, the unconscious parts either remaining untouched or being disordered because of the disturbance in the conscious realm. It is believed that a fair proportion of the psychosomatic patients who seek treatment in the surgery of the physician belong in this category. In the treatment of these conditions it is not necessary to work with problems in the unconscious sector of the mind, though familiarity with the unconscious gives greater understanding to the principles involved in the sphere of the conscious. The division made here between the conscious and the unconscious is genuinely arbitrary and is suggested in the interest of practicability.

The average psychotherapist who is not a specialist in mental matters will encounter a certain number of psychosomatic patients with whom it will be necessary and desirable to go into the personal part of the unconscious. This means only that he keeps going back into the past life of the patient until he has recovered those experiences, impulses, and attitudes that have been forgotten by the patient but that upon stimulation can be recalled without resort to special methods, such as dream analysis or hypnosis. In fact, there are very few patients to whom psychotherapy is applied who do not bring up long-forgotten memories. We are speaking here, however, of those who have always lived

so intensely in the present and future that they acquire a state of mind, the equivalent of amnesia, for the past. Often it is not difficult to help them to uncover the past.

A certain number of patients have vague memory, or a complete loss of it, for whole periods of their lives. Due to emotional causes, they may not be able to recall events, let us say, prior to their ninth or tenth year. Ordinarily it does not take long for the physician to determine whether he is dealing with a matter of a relatively simple blocking off of the past or with a genuine amnesia. When the latter is present it usually is indicative of a situation sufficiently severe to warrant the services of a specialist.

A twenty-two-year-old man, suffering from a heart neurosis, was completely unable to recall any part of his life prior to his eleventh year. He was not at all aware of the loss until he was questioned about his youth. There was enough to review with him about contemporary, up-to-date events, as well as circumstances tracing back to the eleventh year, to keep him occupied for a considerable period. After he had dealt with the reviewable material rather extensively, small and isolated memories came from the forgotten period. Slowly thereafter the memories fanned out until all the essential ones appeared for examination.

Sometimes the blocking off of memories is personal as well as temporal. Try as he would, a patient was entirely unable for a long time to picture his mother as she was when he was a child. Even after he had described his early home, its rooms, furnishings, father, brother, sisters, guests, he could not for a long time

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put his mother in the setting. Time and patience but especially other memories eventually brought her in.

One of the commonest forms of blocking off appears when patients more or less completely lose sight of one side—good or bad—of someone, usually one or both parents. This is another example of suppression or repression, whichever may be in operation, into the realm of the unconscious. It is so important that the physician should always be on guard against believing that the patient has given an impartial account of the character of a person, particularly when the account is all good or all bad.

A patient honestly believed for several years before he appeared for treatment and for some time thereafter that his father had always been kind and attentive to him, while his mother had been cold and spiteful. He was as sincere in that opinion as he possibly could be and he verified it by reference to numerous events in his life. After treatment had been under way for some time he began to see his parents as they actually were, and he was greatly surprised to know that he had seen only one side of them.

Other patients may claim, in the beginning of psychotherapy, that they have always hated the father or the mother. They are sure that is so. They have no information available that it was ever different. While that may be so, it is relatively rare. Usually the hatred gives way to the love and kindness that were either expressed or felt and not lived out.

Hatred, likewise, may be repressed, and the patient may be aware only of love for a parent or sibling or spouse or child. In either instance, of repressed hate

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or love, it is as if the patient were morbidly afraid to acknowledge what is repressed. He wants to have nothing to do with it. As long as the repressed material is not part of a deeply rooted neurosis that has thrown the instinctual impulses into utter confusion, it can be brought into consciousness by the simple techniques used by any psychotherapist.

The foregoing are perhaps the commonest examples of the repression of isolated groups of attitudes and ideas encountered in psychosomatic patients. Their position may be better understood when it is realized that many patients are aware of certain features, so to say, of their past and present emotional reactions, while they are unaware of other features. In some instances what one does not want to see or feel is right in front of his mental eyes, but he will not see or feel. In other cases it is far removed, that is, repressed. Blindness to the issue is an effect in each event.

Those psychosomatic patients whose illness stems from the lower reaches of the mind are more difficult to examine and treat. This is so because in the vast majority of instances the early instinctual life of the patient is distorted, either because of factors that appear to derive from the genes or because of faulty training by the parents or their surrogates. It is often extremely difficult to have an opinion one way or the other, not alone because we are not yet scientifically sure of the issues in this period of biological evolution but probably also because both genetic and environmental factors play their parts.

Through the insight afforded by Freud and others, invaluable progress has been made toward a better

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appreciation of the emotional growth of the child and the influences that the environment, people in particular, brings to bear upon the emotions. This is such a highly specialized zone of investigation, including the treatment phase, that it is believed the inexpert may feel very ill at ease in it. The terminology is usually foreign to him, but more so are the ideas. This is not meant by any means to minimize the results of *preventive* mental-hygiene measures applicable during childhood, especially with respect to interpersonal relationships. What is known about children and parents contributes immensely to wholesome growth, to the warding off of future problems.

Prevention is the core of mental medicine, as it is of physical medicine, and enough about it is known and tried to encourage physicians and others to apply its principles at the earliest time in the life of the child and his parents. The issues involved in the curative treatment of a severe psychosomatic patient, who has lived many years with the predisposition to physical ways of living out a mental conflict, are so complicated today that only those highly qualified should attempt to treat such a patient.

IV

THE INNER MAN EMERGES

THE human organism is a psychosomatic being, a mosaic of mental and physical properties, all united toward the common goal of living as comfortably as possible with himself and with others. The infant starts life after birth as a vegetative entity who must have all his functions (except the autonomic ones, of course) regulated by others. Gradually the mind begins to appear and when it has acquired a certain level of growth, responsibilities for the care of the child are shifted from the parents to the child himself. Throughout this period of growth there is an inseparable co-ordination of mind and body. This is the phase of development in which the principles of psychosomatic growth are laid down.

But growth has only started. The human being is destined to live with his parents for many years, to accustom himself to them, to play upon them as they do upon him, in order to strike a happy balance. He is fated to compete with strangers in innumerable activities. He is designed to mate with another, to become a parent. He must face these plans for him and the multitudinous details that go into the plans. It is a heavy assignment, to say the least, and many people fail to meet it.

The infant is an intimate reflection of the parents who are responsible for his upbringing. By constant repetition he learns how to handle himself, learns what he should and should not do in a given situation, and acquires a

facility for physical and personal outlets. The indoctrination of parental training gives rise to what is known in psychiatry as the *super-ego*, which is in essence the parental code that guides the infant through the intricacies of his little world. Since the code is used repeatedly by the infant it acquires the status of a conditioned reflex or, as is often said, it becomes second nature. As such, it is destined to operate from the sphere of the unconscious, continuing to exert its influence to a greater or lesser extent upon the subsequent periods of growth of the child. The super-ego becomes the inner conscience and is entrusted with the management of the instincts of the id, with which it is in close approximation.

From the standpoint of psychosomatic evolution and growth, the make-up of the parental code or super-ego often decides the fate of the child's later modes of adjustment. Each inner conscience has its own special constitution and that constitution is as closely connected with the child's physique as it is with his psyche. The therapy of psychosomatic problems very often includes as comprehensive a survey as possible of this part of the patient's mind and life, because often the failure to broaden one's interests in life and to get the most out of the succeeding years is a consequence of the inability of the patient to divest himself of inordinate subordination to the disciplines of his childhood. The way the child is taught to regard himself and others is significant for later adjustment.

A child was brought up by a severely hypochondriacal mother, one who worshipped at the altar of physical health. During late infancy, when the disciplines of the

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mother were being ingrained, the child was excessively body minded; all his activities were built around concepts of desirability from the standpoint of physical health and protection. The stools were carefully watched as to frequency, composition, and colour, until that function was ritualized. Imitating the mother, the child became a food faddist and in late association with children was taunted because of his fussiness over food. The habit was perpetuated into his adult life, was one of the factors that played a decisive role in the selection of his fiancée, for she fitted in nicely with his food idiosyncrasies, and in marriage it was an essential focus of interest.

Food whims, however, like a large number of other peculiarities, gain primary significance because they are an emotional bond between parent and child. Food is more than food; it may, and often does, serve as a vicarious vehicle for the expression of moods that stem back to the parents.

But food serves as a single instance of human relationship. The parents may not be interested in food; they may stress punctuality at the meal hour to the point at which moods of a pronounced character are created. To the child, eating becomes a time habit, one that is ritualized far beyond the bounds of reasonableness. Parents who are thus time-minded spread the issue to all the other activities of the child so that the child becomes an automaton, a human timepiece. It needs to be emphasized, though, that time is more than time; it is an emotional link in the chain that binds the child to the parent and the parent to the child.

Another instance of emotional bearing connected

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with eating is cleanliness, the insistence upon which may be influential in conditioning the child throughout life, depending upon the emphasis placed upon it and the manner by which the subject is implanted in the child's mind. The meal hour lends itself favourably to indoctrination in cleanliness, or to its opposite, or to any intermediate set of habits. The focal point of interest to us at the moment is the emotional service to which the concept of cleanliness is put. One of the most powerful bridges between parent and child may be constructed out of cleanliness, over which a wealth of emotions may pass.

Not infrequently the child who has been brought up to sanctify cleanliness is beset with a dread of uncleanness, a dread that permeates his moral as well as his physical life. He may well grow up with a fear of disease which is later expressed as certainty of disease. When later he resorts to the medical field for help, he presents the symptoms of his alleged disease; that is, he presents the end results of a chain of circumstances. The physician gives the patient the benefit of all the physical skills known to his profession and reports back a long list of negative results.

It is an axiom of psychosomatic medicine that *symptoms convey more than a message from a disordered organ*: they carry, to a greater or lesser extent, the substance of the mind, the emotions, and all too frequently organic symptoms hark back to the early life of the patient, who is doing no less than repeating a formula of conduct reminiscent of the time when, in trouble, he sought solace from his parents.

The passing of the family physician is to be regretted,

since it was he who knew the emotions of his patients, their philosophy of living, their likes and dislikes, their assets and liabilities; he recognized what role the physique played in disrupting their daily life; he knew the strengths and weaknesses of their feelings. He prescribed for both. With the growth of specialists—and there are today some twenty different specialties in medicine—the human element of the practice of medicine began to lose much of its value. It is not enough to call in a psychiatrist to supplement the organic efforts of the specialist. This is an artificial expedience. It is far better for the patient to have the same man gauge and treat the organic and emotional factors that go to make up the total illness. It is no more difficult for the gastroenterologist, for instance, to learn the technique of investigating the emotional life of the intestinal tract than it is for him to study and treat the tissue itself. This is not to say that psychiatry is easy to grasp, nor gastroenterology, but it does mean that many of the emotional problems that pervade the alimentary canal can be handled by that specialist.

The early life of the child is made up of a host of actions and reactions, almost all of which are heavily invested with feelings. It is the fate of the experiences that they must be largely relinquished in favour of new sets of experiences. By relinquishment is meant not loss but rather the relegation of infantile thinking, feeling, and acting to a state of unawareness. As a working hypothesis it is said that the experiences go into the unconscious part of the mind. Their storage in the unconscious does not at all mean that they are therewith divested of their emotional components. On the

contrary, the extraction of energy as emotion from earlier experiences is a slow and painful process even under the most auspicious circumstances. Nature provides years for the gradual translation of feelings from the events of infancy to those of childhood, always leaving a given quantum of emotional energy with the original experiences.

Unhappiness during the years to come may be occasioned by a variety of conditions, but the unhappiness that persists for years almost invariably springs from the early years of life. It is so much easier to get along with the known past than with the unknown, untried future. Many people find it impossible, or nearly so, to keep on advancing through life; neither do they desire to go back, though the past is always beckoning to them. As a patient expressed it: "I'm wobbling on a tight-rope, high in the air; I can't go forward and I'm afraid to fall."

If man's mind, and all that goes into it over the years, were always right out in front of him, there would be at least two great disadvantages. In the first place, there would be an overwhelming plethora of experiences and their emotional associations. Such a state would be the equivalent of placing several months' supply of food on the dinner table for a single meal. There would be great profusion and confusion. In the second place the wastage would be tremendous.

As extravagant as nature is, she nevertheless makes provision for psychological economy. Indeed, she stores up the bulk of infantile experiences, catalogues them, and puts them on the shelf, available when necessary. Since the majority of activities of the infantile period are

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well endowed with emotions, they are carefully preserved, even though as such they are inappropriate for later use.

Nature is man's most prolific collector and hoarder. She collects, retains, and uses a variety of antiques, handed down from past ages. They constitute the instinctual reactions. Ordinarily we feel their urges, though we do not recognize them as concrete drives of the past. The heritage of æons makes itself known conceptually to us through dreams that reproduce primitive methods of the mind. We are purposely omitting any more than mere reference to the phylogenetic functions of the mind because the physician who reads this book will not ordinarily be concerned with surveying the deepest layers of the minds of his patients, either by way of dreams or by other media of expression. When a patient's mental state is such that deep probing is in order to effect a cure, then the problems should be treated only by a specialist who knows his way around that realm.

Attention is called to the fact that phylogenetic, ancestral material is stored in the unconscious. So, too, is the bulk of experiences of the first four or five years of living. Those who are not specialists in psychiatry see a large number of patients whose psychosomatic troubles do not require investigation of phylogenetic issues; they do not need to explore in retrospect the events of the first few years. In many instances cures can be established without going back beyond approximately the fifth year.

Of the multitude of experiences that go to make up anyone's life, not all, of course, are of equal value

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emotionally. Some have little or no value. Nature keeps alive the circumstances that are filled with feelings and they are issues central to treatment.

Nature is selective in what she preserves, stressing particularly the conservation of experiences emotionally connected with people. *Experiences with human beings are the keynote of living.* Reading, writing, and arithmetic, as invaluable as they are, are relatively free from emotions. But the bonds established with people are paramount. It is the early interpersonal relationship, indelibly imprinted upon the mind that constitutes the pivotal issues in psychosomatic medicine.

It has already been brought out that the infant's introduction to the environment is almost exclusively a body to body (not a mind to mind) relationship, particularly with the mother. This is so during the early months in such matters as food, elimination, sleep, dress, warmth, and so on. Gradually each of these habits undergoes modification in the sense that the mother's mind, or rather her instructions, slowly displaces her direct physical charge of her baby's bodily habits.

The implantation of disciplines that are imposed upon the child's growing mind is mainly concerned with the child's bodily functions. This is one of the most significant phases in the evolution of the child's mind, a phase that in numerous instances is only slightly modified over the many succeeding years. A hypochondriacal mother may never essentially relinquish an inordinate claim upon the care of her child's health. Throughout his childhood, adolescence, and adulthood she may try to direct him closely in matters of dress, food, exercise,

and so on, always from the standpoint of health. The early parent-child relationship continues substantially unchanged.

Let us not attribute the fault of such an arrangement solely to the mother. Perhaps an even more important factor is the unwitting receptivity of the child's mind to be so influenced. The mind of the child is unusually responsive to the particular type of conditioning to which it is subjected. That fact is extremely important to the understanding of psychosomatic medicine.

All children are not born equal emotionally. Some are so weak in this respect that they cannot for one reason or another enter a new epoch of growth, perhaps because they know how to manœuvre themselves better with the old ways than they can with the new and relatively untried ones. The dread of new situations (neophobia) seems to be as much of a deterrent to advancement as is conditioning to old habits. With both factors operating upon the growing mind, it is not difficult to understand why certain people are so unevenly adjusted to life. Add a third feature, namely, the difficulty on the part of the parent to free the child from herself, and the problems of unwholesome and irregular emotional growth become even more clearly understandable.

We cannot forget that the initial ties are somatic first, then psychosomatic. Moreover, even in the healthy child this psychosomatic relationship lasts at least until puberty.

It is as though the parent takes hold of the child's emotions as they come forth through the organs of the body. Mother (and/or father, grandparent, aunt,

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uncle, brother, sister) is the child's first social worker, takes each impulse as it appears in the child and makes it conform first to her way of doing things. She bathes and feeds him, removes waste material, keeps him warm, and so on and on. So close is the baby to her that he appears to be an actual part of her. She slowly trains him to take care of himself, and what he does for himself is the first phase of socialization of the instincts. His world is tiny, yet remarkably important. He sees himself as the centre of all he surveys, and it does not take him long to grasp the meaning of omnipotence.

Under normal surroundings his little world beams upon him, adores him and rewards him handsomely for good behaviour. There is no other period in life when boundless praise will surround such simple physical acts as standing up, walking a few steps, picking up an object, shaking a rattle, gurgling, smiling. Thus we see that the muscular activity is among the earliest recipients of adulation. With growth, it continues to be the object of admiration. The family flag is hoisted when the child runs across the room, when he somersaults, when he gets up on his dining-room chair alone. Action and adoration are equated with each other. Some children never forget the praise showered upon them; they keep looking for applause upon the completion of some childish behaviour for which they were previously richly rewarded. They discover that the outside world is not as extravagant with honours as is the home. The vast majority of people earn most of their medals before their fifth year, though the quest for honours is interminable. *Childhood is the period of posture and gesture, intimately bound to the psyche.*

THE INNER MAN EMERGES

Motility cannot ordinarily be carried through life as an end in itself, save, perhaps, in such professional careers as acrobatics. We then say that infantile acts have been sublimated, meaning that they have acquired social value, including usefulness to the actor and the observers.

After the phase of infantile vegetative existence has passed, action becomes a definite psychosomatic issue, occupying an important position in the lives of all. Frequently it becomes the servant of the mind. This is particularly true when the person cannot adequately cope with a situation mentally. The little child may learn that the most effective way to conquer the gigantic mother or father is to throw a tantrum. Literally, tantrum means tension and refers to the infiltration of muscles with emotions. A tantrum is a pristine manifestation of psychosomatics. It is often a highly effective, though later a morbid, type of response. Many psychosomatic problems in medicine are little more than tantrums, modified slightly to remove the stigma of infantility. It is not especially concealing, however, to stamp out of the room as the answer to a lost controversy or to stand akimbo in defiance of opposition. Muscularly expressed emotions of such intensity are decidedly primitive; they can be capitalized through stagecraft and thus earn a place of esteem, but outside of showmanship for showmanship purposes such use of the muscular system is incongruous.

The object of the present discussion is to stress the point that, for instance, *the muscular system is not infrequently used to express the emotions*. Many abnormal postures, gestures, paralyses, bizarre activities, tics,

choreiform movements that baffle the physician for some time are but thinly disguised manifestations of a mental conflict. The emotional situation may appear as muscular pain or spasm or fatigue or paralysis. The hysterical person is an experienced mimic, or, more correctly stated, the muscles are trained to mimic the mind.

The substitution of a muscular phenomenon for an emotional conflict usually is an act of the unconscious, though originally it was a conscious or partly conscious process. It is almost automatically recalled into service as a way of solving a situation that the conscious mind cannot handle.

The vegetative or autonomic or self-regulating nervous system is the system par excellence through which the emotions find vicarious outlet. The mouth, throat, stomach, intestines, and rectum comprise a continuous tract through which emotions as well as nutriment pass. Normally throughout the infantile period the child's food is richly mixed with the guardian's emotions and is followed through the length of the alimentary passage until it is expelled. Often the gastrointestinal system is the pre-eminent bond that holds mother and child together. A mother who cannot love her child may pamper his alimentary canal as she undoubtedly does her own. He is merely a projection of her troubles and as such may grow to know his alimentary tract better than he knows himself. Not a few patients take only that part of their anatomy to the physician—bones, muscles, and head being simply a convenient form of transportation for the alimentary system.

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Since the mother is usually responsible for the child's early years of growth, we have generally referred to her alone for the sake of convenience. She may be passive, however, and be little more than a nursemaid who takes orders from her own mother. Or the father may issue and supervise the orders. The possibilities are many, yet their multiplicity has, as a rule, a common denominator, namely, the emotional factor. The ratio of emotional to food content may be as two to one or three to one or one to three. It is never zero to one, because a completely negligent mother provides the opportunity for the child to mix his own emotions with his food, for he keenly feels her absence in the process.

The healthy parent helps the healthy child eventually to divest the alimentary tract of the infantile ratio of emotions to food and its bodily connections, diverting most of the emotions to other channels—for example, to the building up of intelligence—but retaining enough in the tract for reasonable care and attention.

Weaning is not only an oral nipple process. In due time the child's muscles are weaned from the mother's muscles; she takes her hand away and he holds the object or he stands. The child's intake of food and the disposition of bodily waste are weaning problems. Talking involves weaning. For a considerable period the parents presume to speak the child's mind; the shy little girl of four or five still hands over that assignment to the parents. So accustomed are some psychosomatic patients to having a spokesman that they readily and willingly give that prerogative to the physician. Too frequently he mistakes the gift for one of his skills.

All of these weaning acts lead the normal child into

forms of activity appropriate to the succeeding periods of growth. Some weaning processes require considerable modification, others very little. It all comes under the heading of civilizing the instincts, though it is more nearly correct to speak first of parentalizing them.

If there is any single factor in psychosomatic medicine it would be difficult to find one more important than parentalization of the instincts. It is almost incorrect to refer to the infant's room as a nursery, as if the room belonged to the infant. It is a "parentorium."

Biology, reinforced by society, deputizes the parents to bring up the child. The only social qualification for this office is marriage, but the imposed duties are extremely light, namely, those laid down by the health officer. Society provides more stringent regulations for the tradesman than it does for the potential parent, yet from the medical point of view a tradesman never consults a physician because he is a tradesman, but a parent often consults a physician because he is a parent. All too frequently the parenthood is concealed behind real or alleged physical complaints.

One of the real reasons for living—happiness—is left to chance. Religion makes a noble gesture and is remarkably successful in its efforts, though it does not pretend to solve those emotional problems that appear in the guise of organic complaints or those emotional issues that conceal themselves in genuine disease. Other institutions of society—law, education, recreation, and so on—contribute their share to the quest for happiness; still their emphasis is placed upon their more immediate professional needs.

From the standpoint of psychological medicine, the

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basic unit of society—the family—is neglected. The only reason for raising that point here is to call attention to the fact that medical science is technically prepared to assist in the solution of one of the important causes of personal unhappiness, namely, the unwitting delegation of emotional authority to the organs of the body. That is the gist of psychosomatic medicine.

PSYCHOLOGICAL *VERSUS* ORGANIC SEX

THE old proverb, "As ye sow, so shall ye reap," should be supplemented by another, "As is sown by others, so shall ye reap." The first proverb places all the responsibility upon the reaper. To be sure, he is entitled to his share, but he is by no means the product of only his own seeds. What he reaps is a resultant of seeds from many sources.

Man is mentally a hybrid, a crossbreed. Not only is he so genetically, but the same two factors, the parents who conceived him, continue for years to direct his growth. This is not simply a figure of speech. It is what we so often come face to face with in our daily practice. It is real; it is dynamic; it makes man grope, often helplessly, for his own individuality, for his own self. His little intellectual ego frequently searches frantically for his emotional self, only to be bewildered by forces within him that control his own destiny. If this is a dramatic way of putting the problem it is so only because that is the way our patients present it to us. Nature trained men for æons to shift the responsibility to his innocent organs. It is only when we begin to look behind the symptoms that we discover the real meaning of them.

Some people, and they make up a fair share of those with psychosomatic problems, subordinate themselves to their instincts and to their early parental training. Their own individuality never acquires autonomy, save at irregular intervals. It is remarkable to see patients go

through life as a composite of nature and nurture, bending low under the yoke of both, seldom straightening up to the erect posture that symbolizes the freedom of independent activity. Patients with psychosomatic complaints are not themselves; the degree of subordination varies from individual to individual, but there is always the question of subjugation to the past.

What makes the early life of the psychosomatic patient so significant for later clinical syndromes is the fact that the totality of parentalization, with its kaleidoscopic emotions, is indelibly a part of him, a fundamental part, from which he cannot be adequately emancipated. In him adjustment to later levels of growth is tenuous. There is always the tendency to go back to the past, even when that past is in truth far inferior to the present. It seems odd that a mother with two fine youngsters, a good home, with no financial worries, should slip behind an organic set of symptoms, falling back in her alleged diseased condition upon her parents because her husband is inattentive to her. Yet her early home life was unhappy, for her father was a drunkard and her mother neglectful of her. The old state of lovelessness under which she had been brought up was being repeated and she did not have sufficient resourcefulness to correct the existing condition.

Parents, or the images of them, are the Gordian knot of many patients. The latter may appraise their parents soundly from the intellectual point of view, conclude that the knot can and should be untied yet be unable to do it emotionally. This is especially true when the composite image of the parents has solidified in the unconscious part of the mind.

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It was previously mentioned that the animalistic tendencies of infancy gradually reach the environment through the medium of the parents. All the physical needs of the child are prepared for appropriate action—all but one, and that one is the only means by which nature can perpetuate man. Therefore nature energizes the reproductive apparatus to a high degree and makes the penalty for its denial a severe one.

The infant does not have sex as that term is popularly used. It has gender, belonging to the class male or female. During the first few years the external genitalia have no objective aim. However, being energized as are all other parts of the body, they are capable of excitation which is for some time confined to the body of the child, as are hunger and thirst. There is an awakening of genderistic impulses, however, at about the fourth or fifth year. An interest is developed in the zone, an interest that the child would have the mother attend to, since she never hesitated to answer any of his other bodily needs. Indeed, he was conditioned to receive prompt and gratifying action.

The mother would answer this urge of the child if she could handle it in a way similar to the way she treated other urges, that is, by directing the energies into socially acceptable channels, by sublimation. But genderism does not lend itself to social modification as does alimentation or elimination. In the two latter processes the energies of the organs are kept very much alive, though under special conditions. The eyes, ears, nose, throat, and skin are the objects of constant and overt training; discussions on the special senses are encouraged in open forum. In almost all societies,

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however, one organic system gets no positive training from the parents. In fact it gets neglect or hostility. In a way it is unfortunate that gender, innocent as it is in these early years, cannot be satisfactorily handled, yet it seems that it cannot be under known methods, because when given full expression, with only the child as the object of its own excitation, the groundwork is richly prepared for great perturbation in the succeeding years.

There seems to be a more or less common course for the energies of genderism to pursue. Nature enlivens the reproductive zone of the child for quite a period of time before the parents become aware of it. The parents themselves lengthen the period by wittingly or unwittingly disregarding that phase of the genitalia. But the child is not without a great deal of energy in that field. He is usually prevented by the parents from displaying the interest, but prevention of display is only that and no more.

Because the child is conditioned to have all his other energies managed by the parents and because the repetitious training has resulted in the formation of a code of discipline (the super-ego), conditions are already set up for the reception of the energies of the genderistic zone. This is a remarkable provision made by nature. The parental code is in full operation in the unconscious before the energies of gender are sufficiently developed to seek expression elsewhere than at their source, the reproductive apparatus. The energies go to the parental image in the unconscious sphere where they are allowed full play, but only in the unconscious. Thus there is created in the part of the mind to which the child has

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no access a union of child and parents in terms of gender, the forerunner of sex.

The genderistic union of child and parents is more that a hypothesis, for it can be demonstrated upon investigation in any number of children. Furthermore, it is a common finding among patients who undergo deep psychotherapy. It is a frequent topic for solution in psychosomatic medicine. Although the concept is simple to understand, it cannot easily be uprooted for two reasons. In the first place, it is strongly embedded in the unconscious, being in direct connection with and therefore gaining heavy reinforcement from the primitive instinctual urges arising from the id. Second, identification with the parents on the basis of gender is generally an unacceptable thought to the conscious mind. The patient grants readily that he identified himself with his parents in matters of eating, dressing, cleanliness, philosophy, education, and so on, but he is averse to believing that even unconsciously he could ever have had the psychology of tying his gender to his parents. It is readily understandable, therefore, that this impulse, strongly energized, is prevented by the person himself from becoming known to him. When the pressure becomes great enough to force this genderistic urge out into the open, the urge is detoured by way of physical complaints, so that the patient, without psychotherapy, sees no connection between the unconscious impulse and its physical manifestations. We help the patient to understand this part of his psychology by explaining that he had no conscious part in its formation and that, moreover, as significant as it is, it relates to gender in a childish sense and not to sex

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in an adult sense. A review of the facts with him will soon show him the difference between the two, thus enabling him to cease diverting the energies from the impulse to the organs of the body. Placement of the energies in the conscious mind of the patient and his understanding of the psychological meaning of the impulse constitute the cure for that particular issue.

The topic remains nebulous to the uninformed because thus far he sees no connection between the psychology and the physiology. It is granted that the patient has both, but what is their relationship? Upon careful survey the patient himself provides the answer. It is well within his memory, though in psychotherapy he must search for it, that as a child he was in vigorous emotional rapport with his parents and that he felt uneasy, if not sick, physically when he sensed, but did not understand clearly, certain tendencies toward his parents. His physique spoke for him, so to say, or should we say it spoke to him, but not in clear enough tones to be understood.

That kind of communication, from the body to the mind, is a common experience in the adult life of all of us. We sense something vaguely; we feel it in the stomach or in the muscles as tension or we feel it as a head symptom of one type or another; it bothers us, reduces our efficiency, but we do not know whence it arises. Then we get a telephone call saying that the Joneses have been called away and therefore cannot have us over tonight for that game of bridge. Suddenly the emotional scene changes, regrets are profuse and so is relief from the physical symptom. This and a host of other examples could be given to show the relationship

between the mind and the body. The final proof is, of course, empirical, yet the alliance can be reproduced at any time through hypnosis.

While a patient is under hypnosis almost any physical symptom can be implanted in his mind and the symptom will appear after the hypnosis is over. The patient does not know that the symptom was put into his unconscious nor does he know after the hypnosis is over what causes the symptom. He usually ascribes a physical cause to it. A patient under hypnosis was told that after the hypnosis was over, upon hearing the word "noun" he would feel cramps in his stomach that would double him up, and that upon hearing the word "carpet" the cramps would suddenly disappear. Events happened exactly as ordered. Under hypnosis and following post-hypnotic commands almost any set of clinical symptoms can be reproduced through the mind.

The same sort of proof is demonstrable in psychotherapy through free association. It is proof by experience, proof that can be demonstrated hundreds of times over at will. Some of the psychosomatic problems seen in daily practice have their fountainhead in that early phase of growth called the genderistic.

Some parents sexualize the gender of the child in ways that are detrimental to later growth. They may do it by direct participation in the genitals. The child, being nonsexual in a strict sense, innocently enjoys manipulation by the parent, if that is the form of activity indulged in. A father remained latently homosexual until the arrival of a male child, when the homosexuality began to express itself openly with the child. The latter soon came to mean far more to him

than his wife did. When the son was five years old the father had a double bed put in the son's room and for the next several years father and son slept together. Under the pretence of cleanliness the father repeatedly spent much time at the son's pelvic region, much to the innocent pleasure of the latter. But later the son, through embarrassment, enacted many subterfuges in order to escape from his father.

At the age of thirty, after a life of great uneasiness, the son appeared for treatment, for, among other psychoneurotic symptoms, he suffered acutely from abnormal bodily sensations. The patient made very incomplete and unsatisfying attempts to fall in love. Over the years he was most at ease with men. When, however, he came to room with a friend, physical symptoms appeared, mild at first, but very severe with time. During psychotherapy it developed that the physical symptoms at the age of thirty were more or less identified with those he experienced when he was trying to free himself from his father's attentions. They were very disturbing symptoms, thrown up as a defence against the innocent, though unwholesome pleasures of his youth.

The psychology of the parents plays a significant role during this part of the child's life, a role that may reappear later to beset the son (or daughter) with psychosomatic troubles. Parents, wanting a boy, may be decidedly disappointed with a girl. In a case at hand both parents with an air of Calvinistic sincerity brought the girl up as a boy. In her general activities she was a better boy than most boys. The parents did not reckon with nature, which later forced the daughter through

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three unhappy marriages and protracted physical complaints.

In her case another major issue was involved. From the time she was able to walk both parents were so vigorous in implanting their psychology upon her mind that her own mind, that is, the one in her body, was little more than a composite of theirs. She led a bigenderistic life, not a bisexual one, being essentially asexual. Her friends were married couples only, who often remarked to her that she was as affectionate to the husband as to the wife. The larger part of psychotherapy was spent in working through the somatic complaints to the phase of genderism.

A selfish young lady was reared in the doctrine of perfectionism in clothes, manners, gait, speech, cleanliness, propriety. They comprised the altar of worship for parents and daughter. The daughter married her kind and had a daughter who was raised under the same sort of inhuman discipline. The latter became a patient with many psychophysical troubles, the god Perfection being unable to compete with the daily needs of interpersonal relationships, even the simple amenities of social communication. She, too, was psychologically asexual, her principal difficulties stemming from the genderistic level of growth.

It is just as unfortunate to be unconsciously of one or both genders but consciously of the gender that nature put in tissue form. This psychic combination is bewildering, particularly when one of the drives cannot gain and hold superiority. Usually there is an alternation of control, though the superior function at the moment is too severely restricted for free play. This is a not un-

common situation in hysterical women, who always at first present the organic facet of their troubles to the physician. Behind the symptoms is a disorderly free-for-all struggle, with the body as well as the mind the victims. The hysterical woman is at once a subordinated master, yet neither subordinate nor masterful. It is a pitiful combat in which no one wins, a conflict that is waged over a wide area, though principally in the zone of genderism.

Gender is the forerunner of sex. The child becomes aware of his (or her) gender at the age of about two and a half or three, and it comes to mean a great deal to him. Gender does not become sexualized until about the fifth or sixth year. Sexualization may not reach its prepubertal peak until about the ninth or tenth year. We cannot be arbitrary about this matter, because for a time no basic distinction is possible. From the standpoint of psychotherapy it is important to know at least two facts: first, that there is a phase of genderism, a phase that is nonsexual; second, that a number of experiences that are concealed in somatic complaints may be uncovered in the interest of therapy from this age period.

Children who pass through the period of genderism without exchanging love and play with the parents usually lead an incomplete and unhappy life, not only at the time but also in the future. A boy was born to a couple, each of whom recognized even before marriage that they were not in love with each other. They played the game of pretence, which as a game was eminently performed, for their friends often considered them to be the paragon of marriage. The husband and the wife

knew though they really did not wish to know, that their reputation was a fictitious façade. He had not intended to marry—from boyhood he had vowed to care for his parents, who had sacrificed much for him. Much less did he desire to marry the girl who he recognized was in the process of wresting herself from severe parents who forced her into the Cinderella role. The girl resented marriage—she had always hoped to be a business woman and to shake off once and for all the role of housekeeper. They married and had a child.

The boy was promptly turned over to a nursemaid, while the mother chafed under the responsibilities of again being a drudge to a house. The father left home early in the morning and worked until late at night. The boy seldom saw his parents; they seldom saw each other. The mother took a "business" trip to Europe, taking the five-year-old boy with her. She had not been in Europe a month when she sent him back to the United States, while she remained seven months longer.

The boy was met at the pier by a bachelor friend who took care of him for the next several months. Over the succeeding years the boy was in school away from home, save for brief vacations which the parents filled in with a tutor. To all outward and superficial appearances the family maintained a "front" of geniality and respectability, while each of the members suffered in silence.

It was the boy who finally broke under the weight of such a way of living. At the age of seventeen he appeared in the physician's surgery as a patient with chronic bronchitis and symptoms resembling asthma. All physical tests were negative. Study of the boy as a

human being was made, the foregoing account being but a fraction of the facts uncovered.

It was further revealed that when the patient arrived in Europe at the age of five he developed a severe case of bronchitis and was nursed tenderly by his mother for a couple of weeks. Years later, when the boy came for treatment, he said that those two weeks were the happiest of his life because for the first time he and his mother were close to each other. He remembered hoping to retain the relationship and knew that he wished the cough would continue.

His mother tired of the nursing role; she had "business" on her agenda, though in truth the business side of the trip was a poorly rationalized figment of her imagination. She reasoned that Europe was no place for a sick boy, whereupon she sent him back to the United States. A stewardess on the boat gave him what attention she could. He remembered clearly that each evening of the three weeks' trip the stewardess brought him ice cream just before bedtime; sometimes she stayed to tell him a little story.

Throughout childhood he was known as a youngster with weak lungs, and during his school years his extracurricular activities were conditioned by his lungs, so to say. He grew morose, was a sad lad at seventeen, had very few friends, and was plodding through life with a philosophy of hopelessness.

It happened that when he was seventeen the parents could no longer afford to keep him in school away from home. He was grimly happy at the thought of returning, but when he arrived home he discovered that his parents had a carefully worked out plan for him to

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live on the farm of his grandparents, who were getting too old to do hard work. Because he was schooled in stoicism he, too, realized the need for his going to the farm.

But his calm fortitude could not be carried out. The bronchitis was getting worse. It kept him at home, often in bed. The mother thought it was unfortunate that the plans had to be abandoned. The father generously allowed that expense should not be considered and that the boy must be cured of his troubles. He was—by psychotherapy.

To the uninitiated it seems to be unreasonable that bronchitis, real or "feigned," can serve as an instrument to bring people together. Yet it is common knowledge that illness is often the source of tenderness.

There was little sexuality in this boy's life. His troubles were in that department of life designated as gender. He had not risen above the latter to any appreciable extent, either with himself, with boys, or with girls. One theory holds that sex was undoubtedly in him, but under heavy repression. To that theory, it is believed, there must be some agreement, but sex was in the seed, not the flowering stage. A careful study of a number of his dreams failed to reveal sex as such, but did uncover a little boy who was lost.

VI

THE SEARCH FOR RECOGNITION

IN the previous chapter it was seen that there is ample material, recoverable through memory, relating to that epoch of one's growth called the genderistic. During this phase of psychosomatic growth habit patterns of the preceding phase are carried over into the genderistic. The child's mind is constantly adding new material from the environment, new attitudes, new ways of using the older patterns that were necessary during the first half of the infantile period.

It is the belief of many investigators that sexual issues begin to form a part of the child's life early in infancy and that sex has acquired considerable status by the time the infantile period is concluded, that is, around the fifth year of life. To maintain this position the term sex needs to be defined so broadly that it loses popular as well as scientific delineation. This difference of opinion as to when sex comes to gain much importance is not merely one of definition, for it has a very practical connotation.

It is true that the child begins to find his gender at an early age and that the five major senses join forces to give him further knowledge of the significance of gender to living. He develops curiosity about himself and others. He looks carefully at his own body, is curious, compares his structures with those of others. He listens in order to find out how he stands in terms of physical equipment. The other senses enter, usually to a lesser extent, to round out the infantile concepts of the self.

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Gender seeks description and management, largely, however, at this time from the structural rather than from the functional point of view. Nature gives the child gender but for a long time does not functionalize it as sex. Normally gender begins to assume sexual qualities when the child is about eight or nine years old, though under special conditions of growth the sexual aspect may be accelerated or retarded.

It is true that in the psychotherapy of adults the patient traces back his sexual interests to include the parents, particularly the parent of the opposite sex. But as he keeps going back, there comes a definite time when sex with the parent loses its force and is replaced by gender. Gender is here described as involving more or less complete identification with one or both parents, but the degree of identification, in the normal child, is relatively undifferentiated in respect to bodily zones. The genitals begin to acquire a larger proportion of energy some few years before puberty, and at and beyond puberty reach their peak of sexualization.

By the time genitality reaches its acme other interests have been moderately well established and they serve to prevent an overwhelming concentration of energy in the genital zone. Such appears to be the course among normal children.

In abnormal children, however, the phase of genderism is commonly shorter than it is in normal children, while that of sexuality is correspondingly longer, appearing to be heavily repressed in most instances and replaced by psychosomatic symptoms that on first inspection seem to have little or no sexual bearing. The symptoms may not be basically rooted in

sex but in what has been called gender. The relative importance of each in the causation of psychosomatic problems must be worked out in each individual patient.

For purposes of general orientation it should be emphasized that the core of a psychosomatic illness may be related to one of several departments of growth. In schizophrenia, for example, the patient often regresses deeply past the sexual stage, past the genderistic level, and finds his balance, so to speak, in primitive, vegetative living. The patient with a manic-depressive psychosis falls back to a later phase of infancy, to the so-termed somatic level. The hysterical patient does not regress as deeply as either of the foregoing, experiencing her difficulties in the region of genderism and sexuality, though the symptomatology, as in conversion hysteria, is largely psychosomatic. The patient with a diagnosis of psychopathic personality (as a clinical entity, not as a generic designation) ordinarily does not advance materially beyond the sexual stage, though some find their level of adaptation at the narcissistic position. Then there are those individuals who successfully traverse the foregoing regions of growth to reach what is called the suigenderistic level, that is, the period of development when boys affiliate their interests with boys, and girls with girls. Suigenderism is the natural tendency of a child to associate or group with others of his own gender. Morbid fixation of interests may be expressed in this zone as homosexuality, overt or latent. Finally, the inability to grow beyond oneself or one's gender makes it extremely difficult to adapt to the highest level of interpersonal relationship, that of

altrigenderism, the state of association with the other gender.

Of the several levels of growth, one, the vegetative or phylogenetic, is distinctly without objective contact. Then during the somatic phase the environment, narrow as it is, becomes part of the mind and body of the child in progressively increasing degree, causing him, very gently at first, to merge his individuality with his surroundings. The child is slowly but surely swallowed up by the environment to the extent that as he passes through subsequent psychological age periods, he becomes less and less of an entity and more and more of his milieu.

It may be said that the members of society are cruel because they are always trying to impose their ways of living upon one another. The process starts at birth when the mother teaches the child what to do with his physique. Later the parents set up a code for both physical and mental activity. Then there is a long stretch of years in school when intelligence is regimented, while at the same time the mores of the community exert their influences, supplemented by organic law.

Many individuals are unable or unwilling to conform with these numerous disciplines. When the pressure is too great or when their range of adaptability is too small, they reluctantly seek refuge elsewhere, often in the protection of a psychosomatic disorder.

The psychosomatic patient is usually an escapist, particularly the one who has no recognizable organic disease or anomaly. What he escapes to is ordinarily more disturbing, more disquieting than that from

which he escapes, though he is in no position, without psychotherapy, to gauge the relative merits and demerits of either. He is an involuntary escapist, to whom, however, the past may seem a little less disagreeable than the present and future.

A patient, brought up in luxurious inertia by parents who frowned upon work, deserted his life of ease, or shall we say dis-ease, to enter upon and complete a professional course of studies. Because he was well endowed intellectually and because he did much graduate work in a specialty, he later found himself in a carefully organized group in which responsibility was a keynote. By subtle subterfuges he kept pace with the group, but at a great expense to his personality. The more eminent he became professionally, the more he tottered personally. In the effort to keep on an even keel professionally he gradually relinquished interest in recreation, in his wife, in his children, in social affairs.

From luxurious inertia, with all its selfish returns, to intellectual wealth, with emotional poverty, was too great a departure for him. The solution was in the form of persistent diarrhoea, with the usual concomitant signs and symptoms. Through diarrhoea he was able to re-establish idle self-indulgence; indeed, in his illness he recaptured almost the exact living conditions of his childhood. He complained about the "price" but he longed for the condition and got it.

Further understanding of this patient led back to his early childhood, an unhappy, loveless one, with infrequent visits from his parents and then as a rule only when he was ill. He remembered well a severe attack of typhoid fever at the age of six; it was not until

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his condition had become critical that the parents paid him what had all the earmarks of a formal visit. But they were affectionate in manner, if not in heart; they had never before been that way and subsequently repeated their visits only on some such special occasion. They brought materialistic awards to him, tokens of the fact that he was their son.

The diarrhoea that he suffered during the typhoid fever was a prominent symptom to him. It took a desperate illness to get his parents to be good to him. The situation deeply impressed him. Over the succeeding years he "forgot" the formula for affection, chiefly because he sought attention through intellectual channels. He "loved" his work, but that is all he did love. Work in and of itself was cold and heartless. But that was his life pattern. He passed through childhood, through adolescence, through the first half of adulthood resigned to the belief that he dared never to love anyone, for any love on his part would be stopped at the source.

The woman he married was the replica of his mother in looks and action. Courtship was in name only and was founded upon social considerations and their mutual interest in music. He was "too busy" to show love and affection and she was under the dominance of a puritanical mother who would not let her daughter out of her sight. The courtship, sporadic as it was, took on the nature of musical programmes, usually with the fiancé and the prospective mother-in-law as the audience.

They married and had three children, who were brought up under the same formula that the parents had experienced—aloofness, coldness, inordinate accen-

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tuation of propriety and education. The home was like a private parochial school.

The patient's wife seemed not to be influenced by marriage or by the advent of children. The husband and the children were incidentals, much as were the furnishings of the home; they engendered pride in her, as did the paintings by old masters and the unique collection of jewels.

Living as an emotional hermit, however, finally led to feelings of uneasiness on the part of the husband. He became disorganized in his professional work, grew bewildered, lost weight, and had intestinal difficulties which culminated in troublesome diarrhoea.

Sickness is an odd implement for gathering up the crumbs of affection. The crumbs are not sufficiently nutritious; they do not sustain the impoverished body. At best they only delay starvation.

Sometimes, as in the following case, a sick part of the body feels as if it is the mind. The connection between the emotions and the bodily symptoms is sensed by the patient. Often the mind infiltrates the body to such an extent that the person feels that only his body has a mind. One patient actually expressed it that way when he said that his mind was in two parts of his body, his right arm and his jaw. Each area seemed to be a thinking and feeling part of him; he added that it sounded ridiculous to say that each of the parts felt nauseated, loose, and as if it were about to fall off. He had the distinct feeling that his head was a blank and that his arm and jaw were active in a mental sense.

He had sought help from many physicians, had run the gamut of medical examinations, each of which had

been reported negative. He was an intelligent and capable member of his profession, maintaining a good outward appearance to his colleague, though subjectively he felt that he was using his head as a "mechanical keyboard." There were many important emotional features to his life, although, as he related them, his head described the features while his body experienced the feelings.

A bird's-eye view of his life revealed that he had received immoderate affection from his parents, who loved him excessively from the physical and mental points of view. His body and mind were adulated. Indeed, the servile and fulsome flattery was early recognized by the patient as not only excessive and therefore disgusting, but it appeared to stem from very selfish parents who were getting more satisfaction out of the relationship than he. It developed that the parents had grown away from each other and were competing vigorously for the child. He was in an emotional vice, one jaw of which resented the mother, the other the father. It closed relentlessly upon him throughout childhood and adolescence. He began to hate the feigned devotion, yet he never indicated his resentfulness. On the contrary, he became a better actor than they.

Both parents died within six months of each other when the son was seventeen years old. He was tearfully relieved upon being freed from the unnatural role he had been playing. His body and mind had been sanctified by his parents. To them he was not a person of this world, and in truth he was not. When they died he was left emotionally alone, with a fine physique and a brilliant intellect. But life was a baffling and con-

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fusing network of passages, a labyrinth through which he could not find his way. His form of psychoneurosis was to build up the resentfulness that he secretly harboured against his parents, induced by his realization that the ways they were imposing upon him were not preparing him for life and living. The children in the street laughed at him, dubbed him Little Lord Fauntleroy, a mamma's boy, a sissy. He tried to shake loose from his parents but could not. For several years after their death he made excellent intellectual inroads into the environment, at the same time detesting the means by which he was gaining recognition.

He was a young and promising writer who had already established himself in a select circle. He was thinking, not feeling, his way along. He was often tempted precipitously to throw his intelligence away, go to some distant region where he was unknown and start life over again, this time as a plain, ordinary human being. He could not follow such a plan. Bewilderment seized him and took the place of the intellectual way of living. To be sure, he did not reason it out so at the time. Finally he had to give up writing, for he could not think.

The right arm, the arm so useful in his calling, "went back" on him, as he said. Jaw symptoms soon followed. He always described himself and his parents as mouthers, as affected declaimers, and he hated himself and them for their mouthings. Whereupon he unwittingly developed the agonizing feeling that his jaw was dropping off. He became a jawless, brainless, armless patient.

From one point of view it may be said that he had no alternative save mental and physical incapacity. He

had had no training along natural channels of emotional outlet. Everybody liked him and sought his company, but he hated himself for his play-acting role. And inwardly he hated people for not having intelligence enough to detect his pretensions. He described himself as an idiot and a misanthrope, but claimed that at heart he was neither.

When he came to understand the relationship between his symptoms and his upbringing, he was able properly to see the part he had played in his parents' life and the part they had played in his. He understood the cause of his symptoms, and they left him.

This thumbnail sketch is just that and no more. It does not include a variety of experiences, unrelated to the symptoms but stamping him as a person trying to negotiate his way into this or that panel of activity. He led a varied life, more, however, in the sense of an itinerant than of a tourist who identifies himself with the places he visits.

Psychotherapy took all of these "extraneous" travels into extensive consideration, enabling the patient to see himself as others saw him. His symptoms were only the overt phenomena which caused him to seek help from the medical field. When they had been removed and when he had gained a substantial understanding of himself as a human being, he began to reconstruct himself. Psychotherapy does not end with the removal of symptoms. In fact, psychotherapy of symptoms leaves many patients as helpless as they may have been before the symptoms were removed. The question of psychosynthesizing patients, after psychoanalysing them, is a subject for later discussion.

VII

SEX BECOMES VITALIZED

SEXUALITY plays a remarkably significant part in the lives of many people. Its bearing upon psychosomatic problems varies from great prominence to a role subordinate to other trends of interest. It has many ways of expressing itself, the genitalia constituting the central zone. Just as with other instinctual drives, under given circumstances many parts of the body join in the service of sexuality—the sense organs, the musculo-skeletal system, the central and vegetative nervous systems and their connections. But there are two principal bodily areas—the oral and the anal—which early acquire sexual importance, to the extent that they may equal or surpass or entirely replace the genitals in sexual activity.

It is not proposed here to refer to the many finer details of sexuality, especially to those that are discussed by the highly trained specialist, because many of the problems subsumed under the caption of sexuality of infancy, while fascinating from the scientific point of view, have not yet achieved the distinction of therapeutic applicability. That is not true for isolated instances, but it is true for the general run of clinical material. Even if one were to allow that sexuality begins to appear within the first year of life, it would still not be possible to use the information therapeutically directly with the patient later in life. The current value of such data is largely in the field of research and prophylaxis instituted by the parents.

The age at which sexuality as a vital issue known and felt by the youngster appears varies from child to child. It is not unlikely that, aside from occasional fluttering interests before the age of eight or nine years, sexuality begins to show some measure of permanence in that age period among normal, healthy children. The groundwork for sexuality is laid during the period of genderism, when the child's attention is directed to his own gender and to that of the parents.

From the psychoanalysis of adults it *seems* that overt sexuality toward the parents extends back into the life of the subject as far as he can remember. Erroneously he ascribes to genitality many experiences and impulses which in truth are genderistic. This is particularly true in the analysis of patients who have never been able substantially to emancipate themselves psychically from the parents. The wish that it should be so is often strongly entrenched in the unconscious mind of the patient and, according to the accepted doctrines of psychoanalysis, the tendency toward that belief is encouraged by the analyst.

It seems true that among a certain small proportion of individuals sexuality is truly aroused within the first few years. It is equally true that in special instances also the appearance of sexuality may be delayed until puberty. It is perhaps more in accordance with the facts, which are not as firm as we would wish them to be, that for the average individual, in sickness or in health, sexuality as genitality begins to appear four or five years before puberty. We would, therefore, place its beginnings between the stages of genderism and adolescence.

Sexuality has its own peculiar meaning, but that meaning is appreciably influenced by the setting in which it occurs. Sexuality is a direct continuum with genderism. Hence, as already explained, it is understandable why the child, schooled in directing all his problems towards the parents, also directs his sexuality toward them. It is an innocent though a remarkably forceful impulse. In the early stages of sexuality the child ordinarily has no conception of the functions of the drive; he does not know toward whom to express it, nor toward what. The child is bisexual biologically and psychically. Therefore the sexual urge is toward both parents, as well as toward himself.

The child's general interests at the time that sexuality is aroused are greater than those of the period of genderism. Usually he has a number of playmates with whom he shares a part of his energies, usually in wholesome play, at times in sexual investigation. Then, too, a part of his energies goes into the service of intellectual achievements, particularly through schoolwork. School-teachers begin to assume the role of part parents. A fresh set of social requirements is inaugurated. New points of view are established, all of which tend to reduce the energies which once were almost wholly of a child-parent nature. Now it is child-parent-teacher-playmate. It is in this manifold group of activities that sexuality in a genital sense begins to take a part, but not, however, before it has been initially connected with the parents.

While it is the rule in healthy families that the son leans in the direction of the mother and the daughter in that of the father, the relative strength of the personality

of the mother and father often determines the growth of sexual interests in the child. A parent or both parents may be absent in emotional relations with the child ; or one spouse may dominate the other to the extent of quashing the other's influence in the household. Or one parent only may be in the household. There are many possibilities, including the strength of character of the child himself as well as the interaction of other children in the family.

It is not to be presumed that the parents or others are always the cause of the child's unhappiness ; the cause may reside within the child ; the parents may meet all the requirements of sensible upbringing of their children. The physician should not draw conclusions until all the facts are in that warrant conclusions. It is just as possible that a child cannot emancipate himself from his parents as it is that the parents keep the child in subordination to prevent their losing him. Cases of both possibilities are often seen. A parent, sensing that she may have to give up some emotional control in favour of others, may fall back upon a psychosomatic illness as a means of retaining the child as she had always done. The child may resort to sickness as a defence against losing her.

The groundwork of the child-parent relationship is almost complete before the introduction of the genital phase of growth. Among normal children genital identification with the parent is repressed into the unconscious, from which situation it continues to operate, but in a sublimated, socially accepted manner. As such it constitutes a normal problem and is commonly not destined to plague the son or daughter later in life.

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When, however, the genital issue is too strongly associated with the parents, some type of unhappiness is usually the result. But genitality is only one link in the chain that binds the child to the parent or vice versa. Not all the links, of course, are of equal strength; they generally are not. Genitality may or may not be the strongest. Nature endows the child with egocentricity (narcissism), with omnipotence, with love of his own body (somatoeroticism), with gender, with sex, with identification with the parents and others. When most of these issues cling to childish forms of expression, some type of maladjustment is the usual result. Any of these problems, any combination of them, or all of them together may comprise the cause for illness. Each one can and does, under given circumstances take a vicarious mode of somatic presentation.

Among the mentally unfortunate group of human beings, especially those with one or another of the formal psychiatric disorders, genital impulses of pre-pubertal origin usually play a conspicuous role. Those impulses, improperly resolved at the proper time, continue to exert powerful influences in the life of the patient. They are seldom known to the patient for their true meaning, because the energy connected with them takes a symbolic route of expression. Psychosomatic medicine is largely the study and resolution of psychogenic troubles which can be externalized only (without psychotherapy) through organic symptoms. This is especially though not exclusively true as regards unconscious genital drives identified with the parents.

The simplest version of genital conflict is that commonly known as the Oedipus complex. It is ages

old, coursing through all manner of peoples, and it is as true today as it was in bygone centuries. There is nothing new about its essence, although until Freud it had greater significance as folklore than as the grim tragedy of family life.

The story concerns a son born of the King of Thebes, Laius, and his wife, Jocasta. The king had been told by an oracle that he was fated to be killed by his son; upon the birth of the son, Jocasta gave him to a shepherd with orders to leave him on Mt. Kithacron to die. The compassionate shepherd, however, gave the infant to the childless King of Corinth, Polybus. Oedipus did not know that his foster parents were not his real parents. When he came into puberty Oedipus consulted an oracle, who told him that he would kill his father and form an incestuous union with his mother. To prevent himself from so doing Oedipus decided not to return to Corinth. He wandered over the land, met a powerful man with whom he quarrelled and whom he slew. Oedipus continued on his journey, arrived at Thebes, where the Sphinx presented a riddle for solution. Oedipus solved the riddle and in gratitude the Thebans gave him Jocasta in marriage. Children were born of this union. Again an oracle intervened to tell what had happened, namely, that Oedipus had killed his father, married his mother and had children by her. Oedipus, therefore blinded himself, castrated himself in some versions of the story, while Jocasta hanged herself. He wandered away, accompanied by his daughter, Antigone. He was eventually destroyed by the avenging deities, the Eumenides.

Such is the Greek mythological story, mythological

in one sense, but true to the everyday life of not a few patients. Except for a change of names almost the exact version can be gained from the spontaneous utterances of the schizophrenic patient, for example. It is repeated by patients who never heard a single word of the tragedy. It is inborn; it is a part of that deep sector of the mind in which the ancestry of the race resides. It comes into consciousness in pure form among those patients, usually schizophrenic, who regress to the vegetative level of existence. But it is not by any means limited to schizophrenic persons.

The Oedipus complex is normally resolved with little difficulty. At puberty the son really begins to grow away from his parents. Usually there is some turbulence in the form of resentfulness on the part of the son, more so, as a rule, toward the mother, but also toward the father. Under the best of circumstances the emancipation is not easy. There are all grades of responses, up to and including the most disabling mental disorders.

In the practice of medicine there is a large number of patients, not including those with a severe mental disorder, who present physical complaints based unwittingly upon the Oedipus situation. Generally their clinical syndrome is unique in the sense that the combination of symptoms often does not conform to any known organic set of symptoms. Also, the organic accompaniments of organic pathology are absent. Moreover, laboratory findings are either absent or are irrelevant to the complaints.

A woman, married, with two children, had suffered from headaches for a few years. All organic examinations

were negative and they had been extensively repeated over the several years during which the headaches persisted. A laparotomy was done in desperation; a small ovarian cyst was removed. Nobody expected the removal of the cyst to influence the headaches and it did not. Eventually she was sent to a psychiatrist.

The history revealed that she was an only child, unwanted by the parents. The father was a drunkard and was seldom at home. After the patient's birth he infected his wife with syphilis, from which she died a few years later. In her infancy she was adopted by foster parents, and the only father she came to know was her foster father, who was loving and devoted to her. It made no obvious difference to her when later she was told about her parents, because the foster parents had always been as real parents to her. The foster mother died when the child was seven years old. The foster father and the child lived for each other; they were inseparable. "Throughout my adolescence Daddy was my beau," she explained. She reasoned that it would be utter betrayal of her father if she accepted attention from another man, though both realized that she ought to do so. She was an active, alert girl, fine in appearance and manners.

She had not experienced any troubles until she was about twenty-two years old, when the habit of masturbation was renewed, after it had remained dormant for about eight years. The practice had begun when she was thirteen years old and the fantasies connected with it were built around her father. She was acutely, though silently, disturbed over the situation, tried with great vigour to cease the practice and succeeded only

when she developed what she called "disgusting, nauseating headaches," which even then she thought were emotional, not organic, in origin. She believed in a vague way that the headaches were caused by masturbation. She eventually succeeded in suppressing all genital thoughts and feelings, so that she became genitally ascetic.

It may be mentioned here that according to the best information available today the psychic trauma of masturbation far exceeds the physical. Indeed, there is no recognizable organic disease associated with masturbation. The same, however, cannot be said about organic complaints, which are very common and which may involve any organ or organic system, from head to foot. The nature of the complaints is largely a reflection of organic symptoms that have been experienced through channels other than the genital. If, for example, a child had suffered for a time with constipation, attended by headaches, sluggishness, and perhaps abdominal cramps—symptoms that brought her close to her parents—then it is highly probable that later, in the presence or absence of organic etiology, some or all of the symptoms may recur in response to the mental anguish occasioned by masturbation.

Masturbation is one of the most prominent of all psychosomatic phenomena. It almost seems inherent in us, however, to give little if any attention to the psychic components. Books have been written about the horrible physical diseases presumably arising out of masturbation. Such concepts have no foundation in fact. The most comprehensive textbooks in medicine, surgery, and the specialties fail, as a rule, even to mention the

term masturbation; those books that mention it do not identify it as any organic disease.

Not a few psychosomatic syndromes, however, are based essentially, though not exclusively, upon masturbation and its psychic associations. Masturbation has decisive mental significance. Its practice often keeps the individual emotionally bound to himself; that is, it perpetuates narcissism, particularly the type of narcissism that keeps a boy a son, so to speak, or a girl a daughter. It narrows emotional outlets, encourages aloofness, and minimizes a full expression of companionship. The treatment of psychosomatic problems, behind which are concealed a masturbatory complex, should always include also the treatment of the personality as a totality.

At the age of twenty-two our patient with protracted headaches began to be beset again with thoughts of masturbation, vaguely relating to her (foster) father. She was considerably perturbed when she briefly surveyed her life, seeing it as essentially a father-daughter way of living. She keenly appreciated the unwholesomeness of her situation, but she dreaded making any move to remedy it. Her emotional position in life was bad enough, but the solution of it seemed far worse to her.

She precipitously escaped through marriage. Since her only preparation for marriage— and of course it was the wrong kind of preparation—were the associations with her father, she unwittingly fell into the emotional trap of marrying a man who was the “dead image” of her father. Because she had never known any role other than that of a daughter, she carried over into courtship

and marriage the habit patterns of her past. Somewhere out in the periphery of her thoughts, near the point at which emotions have the quality of ideas, the marriage was felt to be evil. There was something, she did not know what it was, that was misleading, unfaithful. A façade of dignity and grace concealed lowliness and insincerity. Yet she was an honourable girl. Was she? Something in her made veiled references to infidelity.

Man has many obnoxious forces with which to contend, the most destructive of which is his own stealthy, ruthless, and unknown Mephistopheles, who exults in the damnation of the innocent. He is a diabolical, sardonic, irreverent rascal. Religion caught up with him centuries ago and has since done remarkably well in circumscribing his machinations. The written and unwritten laws of society have helped to keep his influences to a reasonable minimum. Innumerable institutions of our society have contributed their share.

It is one of the functions of the medical field, now that it is equipped with an adequate therapeutic weapon, to war against the Mephistophelian influences as they appear under the cloak of innocent diseaselike symptoms. It is one of the unfortunate lots of mankind today that so many people are susceptible to the treacheries of their own inner selves. The millennium is too far off to be seen, yet both prophylaxis and symptomatic cure are established in principle and to a less extensive degree in fact.

Ironically enough, unhappiness, psychosomatically expressed, is too often the cost of conscious decency. It is seldom that we encounter a psychosomatic patient who has not lived with propriety, although overtures from

the inner self temptingly beckon him along pathways of violation. The so-called mental patient suffers little compunction for what he has done in fact, but he suffers immensely for what his unconscious self would have him do.

Our patient was an honourable girl. To her, masturbation was sinful. She did not know why. Nature gives human beings a precious pleasure heavily invested in guilt. Masturbation is the radium of living. It is natural, physiological, useful in and of itself, but under given conditions it is fatal. It is the emotional component of masturbation, associated as it so often is with the parent or parents as the object, that makes the practice "sinful."

Plagued with inner feelings which she kept to herself the wife-daughter proceeded to have two children. The tension of the years of what to her was pointless worry grew less and less tolerable. Her husband said that she had been a child to him before they had children and that afterward she became even more of a care. As he put it, he now had three children. Protracted headaches that were disgusting and nauseating began to bother her. She became a sick person and could no longer be a wife to her husband. The old pattern was re-established, the rejection of the daughter role, although at the time she had no knowledge of that fact. In spite of her symptoms of fatigue and headache she maintained an outward display of pleasantry and tolerance, often to the degree that her physicians thought of hysteria, yet they could not quite believe it. Nor did they believe it when in consultation they compared notes on her flirtatious manner. The comments were without

significance to them, though they momentarily reflected on her previous propriety. Then the ovarian cyst was removed.

Following recovery from the operation it was observed that while she gave lip service to interest in her husband and children she seemed steadily to be growing away from them. It was the only "unwitting answer" she had to the question of the hidden incestuous tendency.

Hers was a clear-cut case of conversion hysteria, a name given to designate the conversion of a mental conflict into physical manifestations. This is a common phenomenon in the practice of medicine, one of the commonest. It exemplifies very well one of the usual processes of psychosomatic medicine.

The question of treatment is reserved for a separate chapter, yet it may be mentioned here that it would have been highly injudicious if the physician, sensing the Oedipus background, had mentioned it by name or inference to her. The essential problem was to elevate her from the position of daughter to that of wife and mother. Incest is mentioned in these pages not as a therapeutic instrument but as a matter of understanding by the physician of the pathology of the psyche. It is urgent for the physician to know the deeper meaning of symptoms, but in the vast majority of psychosomatic problems seen by him it is imprudent and often traumatic to divulge the information to the patient. It is sufficient to call her attention to the facts of the case, namely, that she had not been sufficiently prepared for marriage, that in point of emotional growth she is very little beyond early adolescence. She will not be hurt by

that manner of presentation; on the contrary, she will be encouraged to rise above the adolescent role she has been playing. Nature will free the child from her past by storing away the old clothes and offering new ones. In a large number of psychosomatic illnesses the physician can follow the same procedure with good results. The mere presence of, for example, an incestuous set of unconscious ideas is no proof in and of itself of morbidity. The principal factor is the energy content of the constellation of ideas. Incest, for instance, gains importance only by virtue of the influences it brings to bear upon the daily life of the individual. In normal, healthy persons nature divests the incestuous impulse of the greater part of its energy, stores it away in the unconscious and "forgets" it. The energy from it is invested in other types of security.

It appears that we have confused the boy's problems with those of the girl, since we outlined the Oedipus complex and proceeded to see its psychosomatic significance in the life of a girl. For present purposes no fine distinction needs to be made. The important question here is consideration of a factor of growth, namely, genitality, the ways by which it can operate to delay development toward maturity and the psychosomatic use to which it can be put when conflicts with the self and the environment arise later in life. Fundamentally it is no different with the boy than it is with the girl.

The counterpart for the girl is known as the Electra complex. Electra, the daughter of Agamemnon, King of Mycenae, encouraged her brother Orestes to wreck vengeance upon their mother Clytemnestra and her

former paramour and new husband because they had murdered her father. Electra's broodings over the fate of her beloved father continued until her death. She never married.

When a child identifies himself (or herself) so closely with the parent of the opposite sex, often he continues to emulate the opposite sex in as many ways as is possible. Such close identification prevents him from wholesome masculinity. It usually is an ill omen when both parents tend towards the effeminate. These youngsters are quickly known for their qualities by the children in the street, who usually jeer them out of the group. The effeminate boy eventually finds solace with boys of his type. He stays on the male side of life as a rule, occasionally moving among girls, but seldom forming any well-established, permanent relationship with them.

Not infrequently he turns up in the physician's surgery with some physical complaint, which, if it is an outgrowth of psychological castration or impotence, takes the form of a physical disability. The latter is often the psychological equivalent of the loss of manhood, though of course, it is not known to him that it is so. The sequence of events may be somewhat as follows: the young man broods over his general ineffectiveness in life; he knows he is a success in his chosen field; he accepts the plaudits of his associates with grace. But there is an emptiness about it all. He does not enjoy life as others seem to do. He is a shut-in, though he moves among people. The feeling of emptiness, of deprivation, grows upon him until he begins to feel it physically more acutely than he had formerly. Even-

tually he loses sight of the original difficulty, namely, deprivation of genital activity, and he transfers the element of deprivation to some other zone of the body. The general nature of the complaint is that the organ that plays the scapegoat role is not functioning well. The stomach is a favourite locus for the psychology of deprivation. Weakness of the stomach is a not uncommon complaint; neither is loss of appetite, general fatigue, loss of ambition, and the attendant train of sequences. All examinations of a physical nature are negative. Investigation of the human being who has the stomach reveals that the feeling of deprivation is more strongly rooted in his personality than in his physique. His life has been one of castigation, almost in the sense of chastisement.

The father of a patient died when he was four years old. The mother, an independent, vigorous woman, immediately planned to go to work, leaving the boy in complete charge of a baby sister. He bathed, dressed, fed her, played with her, put her to bed—in fact he did all that a mother was expected to do. He did it for years. He had to wait until she grew old enough to go to school before he could attend school. He grew up as a little mother, took care of the house-cleaning and did what laundry work he could for his age.

His mother and little sister adored him. The mother was a strict disciplinarian and the son was completely obedient, though he sensed that he was not like other boys. He never played, never romped around. There was no fun. At his tender age obedience to duties was all he knew in fact. He was a capable, alert boy and passed through the grades of school much faster than his

schoolmates. He had no friends, no pals. He had the classroom and home.

The pattern of loneliness, emptiness, deprivation was cut out early for him. He took it innocently because his mother stressed it was what he should do. Now and then the feeling of sacrifice came over him, but for years he managed to rationalize it out of the way. He remained the same sacrificial young man through high school and college, but when he came to practise his profession, to make contact with the world of real issues, he was awkward, shy, untrained, but a brilliant statistician. He made his way quickly to the top of scholarship, but he could not negotiate even the molehills of life.

His stomach was the mouthpiece of his deprived life, and to it were ascribed those losses, of which the genital loss assumed an important part, which properly belonged to him as a human being.

It is not to be thought that the organs of the body are so partial that they carry the load only of genital issues. They may and do speak for other troublesome problems, though the genital ones often gain greatest significance. Only an extensive survey reveals the relative role of one department of life over the others. A human being is a mosaic, made of many pieces inlaid to form a pattern. The fault may be preponderantly in an area covering several of the pieces.

While it is not known with complete accuracy why this or that organ comes to assume a vicarious part it may be generalized that that organ or organic system which has acquired emotional significance, particularly in early relationships with the parents lends itself favourably to substitutive representation.

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Certain organs are deputed to act for the personality. Some people cannot stomach certain situations; others are paralysed by fright; some cannot put their heart in a proposition; others gasp for air, clench the fists, blush, turn ashen, get headachy, cry, laugh, break out in goose pimples. The body is the benefactor of the mind. It is the guardian of the personality, coming to our rescue to protect us from ourselves, though in so doing it often creates distress. The mind in turn is the benefactor of the body, for it, too, serves to alleviate physical misery.

VIII

VARIETIES OF PSYCHOSOMATIC SYNDROMES

IN organic medicine physicians recognize the nature and location of disease processes through the grouping of physical signs and symptoms into syndromes. Sets of concurrent signs and symptoms lead to a given diagnosis. Every organic disease has a psychic or mental aspect and every mental disease has its physical. With adequate examination it is not difficult to set the two apart. The requirements for so doing are patience, industry, and intelligence, somewhat in the order named.

Emphasis has thus far been placed upon the influence of mental or personality factors upon normal, healthy tissues or, to put it more conservatively, upon physical structures that are not known to be disordered by virtue of recognizable organic agents. So closely identified are emotions and tissue that it is easily conceivable—in fact the proof is already at hand—that the infiltration of an organ with emotions gives rise to an altered appearance of the organ, representative of anomalous physiology.

“Functional disorder” used to refer to those physical syndromes that are not known to have any of the recognizable organic causes, such as trauma, abiotrophy (early wearing out), disordered metabolism, bacteria, and so on. It is understandable why in the evolution of medicine the study of external, exogenous influences has yielded a wealth of information. With knowledge of the organization and structure of an

organ it is not difficult to recognize the intrusion of an element foreign to the tissues. There was a time when the treatment of the results of accidents and injuries constituted the major part of medical practice. This was the time when the priests and priest-physicians took care of the ills of the body and mind. During those centuries the body in and of itself was conceived to develop troubles only on the basis of external acts initiated by man or God.

Gradually and under the constant threat of reprisals man began to look into man himself for possible clues to illness. The first physician of whom there is any real knowledge was Imhotep (*c.* 2980 B.C.), called the "good physician of gods and men." From then on progress took place by centuries, not by years as it does today. Such ancient names as Kuan Tzu, Pythagoras, Alcmaeon, Hippocrates, Aristotle, Erasistratus, Celsus—the works of these and others influenced the medical world up to and through the eighteenth century. From the death of Galen (*c.* A.D. 200) up to and including Vesalius (sixteenth century)—the Dark Ages of Medicine—"the medical world was almost entirely under the sway of humoral pathology, demonology, astrology, witchcraft and sorcery."¹ Since the Dark Ages of Medicine progress has speeded up; man has looked more closely into man and his more or less immediate surroundings for the causes of disease. The introduction of the microscope to the field of medicine by van Leeuwenhoek in 1683 led to rapid and effective advances. A great number of other technical improvements were

¹ J. R. Whitwell, *Historical Notes on Psychiatry*, H. K. Lewis & Co., London, 1936.

introduced, so that today the skills at the disposal of the medical field are remarkably superior to those of former days.

The point upon which we are converging is this: that the diagnostic and therapeutic equipment of the current era, when applied to the physical side of man's constitution, is inadequate to give us understanding of the origin and development of many illnesses that beset man. This fact was recognized with such keen discernment during the second half of the nineteenth century that two new approaches to human ailments sprung up.

Constitutional investigations moved into the field of scientific research; laws of physical growth and development were established; it was ascertained that anomalous and pathological conditions may be associated with faulty and imbalanced growth and function of organs. This field of investigation has made steady and enlightening progress and promises to occupy a prominent position in the future practice of medicine.

The second new approach was also a direct outcome of the endeavour to find some reasons for the failure of the then known techniques and skills to throw light upon that large group of human ailments that defied any more than a description of the symptoms. Investigators began to look into the personality of the human being. The idea spread that the psyche as well as the soma had biological meaning; hence the term psychobiology and its implications became part of the records of scientific proceedings. Those who gave impetus to the new school of thought were many and illustrious. They paved the way for the epochal investigations of

Sigmund Freud, founder of psychoanalysis. It was Freud who opened and kept open the doors leading into the hitherto incomplete scientific investigations into the mind. Others before him had peeped in, had seen a little and then had withdrawn. Freud went in and stayed in, until he had inventoried all that one man could be expected to appraise.

From the start Freud's aim was the relief of human suffering. The job of cataloguing, however, was so immense that he had to turn the problem of therapy over to others. New concepts arose that were subsumed under a new title—psycho-pathology. After a wobbly start the expression "pathology of the psyche" became a household term in medicine. In this same era, while Freud was working inside, Kraepelin was landscaping the grounds; he was organizing and developing groups of symptoms into clinical entities. The researches of the two were finally brought together and it is the combination of the two with which we work today. There have been many helpers, to be sure, but it is the trend we are emphasizing, not the names.

The two make a reliable and secure structure. To say that it is the best we have today is not to equivocate but rather to allow that improvements are bound to come. It is not good sense to live under the skies when architects provide habitable structures with up-to-date improvements.

Mental syndromes express themselves mainly through two channels of communication, the mind and the body. Pathology of the psyche gives out symptoms or warnings that something may be wrong deep down in. The same law of signalling distress by means of

symptoms applies to the pathology of the psyche as it does to the pathology of the soma. The body tells the mind when something in it is not functioning well, but the mind, though it cannot use any medium of communication other than the body, may assign to the body either a primary or a secondary role of communication.

In the light of present knowledge the concept of primary and secondary roles leads to an arbitrary division of mental disorders into (1) those whose symptoms have a decisive mental bearing, such as fears, anxieties, compulsions, obsessions, delusions, hallucinations, and (2) those whose symptoms appear in the guise of physical symptoms, such as aches, pains, loss of sleep, disturbance of appetite, constipation, laboured breathing, fatigue, mannerisms, tics. It is rare, however, for the symptoms to be either the one or the other. That condition probably does not exist. One set may overshadow the other but does not preclude it.

The same situation prevails in regard to the mind as it does with the body in other respects also. When it is said that a condition is psychogenic it does not mean that only the mind is involved. It does mean that the mind is centrally involved. A cardiogenic disease influences not only the heart but many distant structures as well. The effects of a pneumogenic disorder are reflected in many organs. All organs of the body, including the mind, are in more or less intimate relationship.

The term psychosomatic is a convenience that serves to give location to the principal organ involved. Its analogues might well be such terms as cardiosomatic,

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pneumosomatic, nephrosomatic, neurosomatic, and so on, indicating that while the heart, lungs, kidneys, nerves may be the seat of the trouble, the effects are spread widely over the body.

By the same token that guides a physician away from the secondary manifestations and to the primary source in instances of organic pathology, *the physician working with a psychosomatic disorder carries his examination from the distant to the near part.* That is the essence of psychosomatic medicine. That is the implication in the word psychogenic.

Since the foregoing is at least empirically true, how are we able to distinguish mental symptoms that are tissue bound from physical symptoms that are tissue bound? The techniques involved in the differentiation are radically different from one another, but they are equally available to any physician. It is no more difficult to learn the technique of examination and treatment of psychic problems than it is of somatic ones. The meaning of that statement is equivalent to saying that any physician can easily learn the techniques of the laboratory of clinical pathology, though knowledge gained in the clinical laboratory does not qualify one for conducting more highly specialized and exact investigations.

There are a few important rules to remember. In the first place, among those psychosomatic patients whose problems stem from the mind, traversing the body as a convenient facility of expression, *physical complaints, not physical signs*, comprise what the patient presents to the physician for solution. It is true that not infrequently complaints may antedate physical signs by

quite a period of time, when the cause is genuinely organic. Therefore, it is a *sine qua non* always to perform such physical tests as are indicated. However, it may be taken as a practical generalization that the greater the number of complaints in the absence of organic signs the more likely it is that the trouble stems from the mind.

Second, the *duration of the complaints* often gives a clue to their origin. It is not at all unusual for complaints coming from the mind by way of an organ to be many months or years old before they are placed before the physician. There are very few organic diseases of many months' duration that do not yield at least one definite organic change. *The longer the complaint has lasted, in the absence of data supporting an organic disease, the more probable it is that the source of the ailment is mental.*

Third, it is common to get a *history of the same or similar complaints as of years ago*. In the study of adults it often throws much light on the condition to enquire into the health of the patient during the first half of the adolescent period, for many psychosomatic patients experience in that age period essentially the same symptoms at a later period.

Fourth, *the psychosomatic symptom complex often appears at irregular intervals, usually during periods that are stressful to the patient*. For example, a woman of twenty-nine, single, complained of easy fatigue, "a peculiar mixed-up feeling" in her head and a fear of leaving her home lest she faint in public. Complete physical examination was negative. The history revealed that she had always longed to be married and that she had had a long list of beaux over the years, many of whom had proposed

to her. Whenever it appeared that marriage was in the offing, but not too far offshore for her safety, she developed the same symptoms. To guarantee that the proposal for marriage could not hold, she usually "took sick." At the time of the sickness, however, she had no knowledge of the psychological use to which she was putting the symptoms. Furthermore she found herself far more at ease with married men and with men who let her know that they were in no position to marry. During the first examination she was asked how life in general was with her, whereupon she smilingly gave the answer that she did not know of any girl who worked harder for marriage and got less returns.

A psychosomatic syndrome, like history, often repeats itself.

Fifth, many but not all *psychosomatic patients do not wish to be interrogated for the smaller details of their symptoms*. There is often an aversion, sometimes amounting to resentfulness, when they are questioned at length about their symptoms. The physician gets the feeling that such patients decide before reaching his office just what details they are going to tell him. More often than not, however, they did not make such a decision. It just never occurred to them to go beyond the symptoms even with themselves.

The average patient with an organic disease, overt or latent, usually shows no resistance to detailed questioning about his symptoms. In fact, he is generally pleased with the interest shown.

Many psychosomatic patients seek treatment, with the minimum time given to examination. To them

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treatment has magical influences, and examination is simply something that satisfies the physician.

Sixth, *not a few patients*, such as those with hypochondriasis, while giving no more information than is inferred in the foregoing section, *insist on repeating the same symptoms over and over again*. Repetition gains the same end as paucity of information does. The patient peevishly restricts the physician to what he is willing to give. He may allow the physician to examine other parts of the body, yet he creates the impression that the examination of parts, other than the ones of which he has complained, is unrelated to his reason for calling on the physician.

Seventh, *some psychosomatic patients show almost a compulsive urge to engage the attention of the physician, though they have nothing new to say about their physical symptoms*. They would like to say more, they desire to stay longer; perhaps they know why, perhaps they do not. They apologize for taking so much time, but they would like to remain longer. Each seems to sense that there is something personal developing, and just when an inkling of the real reason behind the visit is about to appear, there is an embarrassing departure. Both are nonplussed.

The truly organic patient usually does not behave in that way. Courtesies are exchanged, but they are recognized as such. Thankfulness is expressed by the patient; it is an honest, frank statement of gratitude that stands alone, does not conceal anything.

The physician would help his psychosomatic patient greatly if he sensed the need in his patient to talk about something that is on his mind, and if he encouraged

him to be as frank with his life problems as he is with his bodily ones. The new and "irrelevant" topic should not be regarded as a personal one; it should be taken with the same interested and professional attitude that prevailed when the "impersonal" body was under discussion. It is entirely to the patient's detriment for the physician to look upon this urge to be "personal" as an "attention-getting device" and to resolve that he is not going to give the patient any satisfaction from that point of view. Certainly the patient invites this attention, and whether he sees it clearly or not, the urge is to get help. It should be "second nature" for the family doctor, *who knows his family as human beings*, to sense his patient's inner and screened urges, perhaps before the patient himself does.

Eighth, *some psychosomatic patients, while recounting their physical complaints, interpose little "asides" that seem not to belong naturally to the general topic under discussion.* Often these "asides" contain the kernel of the mental trouble that is curtailed by the physical complaint. The "aside" may be what is called a "complex indicator," that is, an indicator of a mental complex.

A patient while telling about her physical symptoms, which were many, "jokingly" remarked that if she were married to a woman who was always sick, she would seek a divorce. Further discussion of the "irrelevant" topic opened the real story behind her somatic complaints. In the course of several sessions it was found that she wanted to get out of married life; she did not marry out of love for the reason that she never loved any man. She married because she thought it would be a solution to her unnatural impulse to love

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only women. It was not "just a passing remark" when she included two of her major difficulties in a short, jocular comment, namely, the question of marriage to a member of her sex and of divorce.

The physician need not be "suspicious" about every remark made by a patient. A little enquiry will soon disclose whether the comment is important or not. The general setting in which the comment occurs will determine whether a little elaboration is in order.

A patient with physical complaints mentioned in passing that he was so different from his usual self that "even my secretary commented on my appealance." He did not recognize the error and when his attention was called to it, he replied carelessly that he meant "appearance." The story is a long one, but for present purposes it may be pointed out that he had been vainly yearning for a long time that she would somehow understand the deeper meaning behind the many little nice things he had done for her; he wanted his appeal recognized by her.

Ninth, *when psychosomatic symptoms first appear around middle life* in a person who has up until that time adjusted himself reasonably well and without abnormal reactions to life situations, *it is highly probable that there is an accompanying physical disorder* of a more or less primary nature. At this age period of life repeated observations with respect to physical factors of a genuine nature should be made. The more advanced the age, the greater is the probability that two systems, the mind and the body, are disordered at their sources. One may preponderate over the other, not alone in the matter of symptom formation but also in that of primary

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importance. An organic disease, subtle in onset, may and often does throw the mind into turmoil, causing the appearance of mental symptoms which, in states of sound physical health, might never come to the surface. It is frequently difficult to gauge the relative significance of the one over the other, yet careful collection and evaluation of the facts on both sides usually reduce the probable mistakes of judgment.

The foregoing nine hints or some combination of them are usually a substantial aid in the understanding of those psychosomatic disorders for which no organic etiology can be established. One or more of them may be the open sesame. One or more of them may be the psychic symptom of the psychosomatic duality. The mind is remarkably clever, for it often gives out in psychosomatic instances a vivid somatic picture in which the psychic motive is hardly recognized—a gem with a flaw in it, a flaw not observed by the unaided eye, but which under the lens is seen to traverse the length of the stone.

THE RATIO OF PHYSICAL TO MENTAL SYMPTOMS

The ratio of physical to mental symptoms varies from one patient to another until, for instance, in the compulsive-obsessive form of psychoneurosis, the preponderance may be greatly in favour of the mental side. The closer the psychic syndrome gets to the sphere of the recognizable and classical mental syndromes, such as the psychoneuroses and psychoses, the less likelihood is there of puzzlement with respect to the relative value of organic and psychic features. This is not to say that

the psychoneuroses and psychoses (of psychogenic origin) do not have an organic concomitant, but it does mean that, in the light of current scientific facts, the nature of the organic anomaly or disease, if any, is still to be determined. From the standpoint of treating the patient who is seeking our help, the distortions of the human side of life require a form of therapy built up from the human side; that is, they need psychotherapy.

The more pronounced, and therefore less subtle, psychic manifestations accompanying a psychosomatic disorder may appear as anxiety, distress, exhaustion, dullness, timidity unusual for the given individual, pareses, paralyzes, tremor, depression, lack of concentration, lassitude, fearfulness, and kindred emotional manifestations. It is not difficult, at first inspection at least, to gain the tentative impression that the emotional responses to the real or "alleged" somatic complaints are out of proportion to the physical troubles. Further examination elicits the feeling that the symptom—exhaustion, for example—cannot reasonably be a result of the organic disorder of which the patient complains. The incongruity is too obvious, made more so by the fact that the most exhaustive examinations fail to suggest organic pathology.

A woman twenty-eight years old complained of paralysis over the entire left side of the body, except the face. The condition came on subacutely four months previously. The onset was not associated with any accident, injury, or infectious invasion. All physical tests were negative. She did not look ill in an organic sense but she appeared "all worn out" through worry. She claimed that the worry was bothering her more

than the paralysis. She explained that since leaving home some fifteen months previously she had secured the type of work for which she had longed and that therefore she was very happy with her workaday life. She dreaded losing her job, not only because she liked it so much but also because it would mean she would have to return home.

It developed that it had fallen upon her, when her father died twelve years before, to take care of her mother, who had always been a hypochondriac and who used the hypochondriasis as a weapon by which to maintain complete obedience to her whims. The household was built around her physical ailments. From the earliest years of the daughter's life every activity of the home bore the stamp of the mother's physique. The meal hour, the contents of the meals, the special dining-room chair, pillowed to her comfort, the conversation at the table—all made the mother's presence a ceremonial at each meal, a ritual for her, to which father and daughter were obsequious. House-keeping centred its activities upon her. Their little library was a collection of health magazines, heavily interspersed with religious tracts on health. For many years there had been no holiday celebrations, no vacations—only hypochondriasis. No person ever wielded more power with less exertion; no person ever stood in the spotlight—or was it a thread of light misinterpreted as the fullness of the sun?—as royally as she had. The situation is not being exaggerated by words. Neither a lily nor a cactus can be painted.

The religious aura about the house and the kindness and consideration the mother showed to those who

visited her earned her a warm spot in the hearts of others. The father and the daughter had play-acted the role of contentment so long that they believed it to be sincere.

The father's last wish to the daughter was her avowal never to leave her mother. The earnestness and emphasis that he injected into the vow of obeisance made the vow look synthetic.

The father died when she was sixteen years old. His death made no evident changes in the house or its occupants. She was allowed to continue her education. She graduated from college at the age of twenty-two and worked at her profession in her home town for the next five years. It was not without significance that professionally also she devoted herself to the care of the handicapped. Her social horizon broadened with her professional career, though she continued to remain under the sharp domination of her mother. In soft but effective ways the mother constricted her daughter's activities to herself and to her profession. Gradually, however, the knot on the daughter's side was loosening.

She was offered an attractive new position in New York. Indecision, anxiety, and fearfulness marked the initial discussions of her anticipated acceptance. Finally, under almost unbearable tensions, she departed for New York and her new rise in life, but not until the mother had more securely than ever, if that were possible, tied her to herself.

For the daughter vowed to read certain religious passages every day; the mother would read them the same day, each picturing the other one present. They

wrote lengthy daily letters to each other. The only thing missing was the intimate nursing care that she was accustomed to giving the mother, who, many months before the daughter left home, had developed a paralysis of the left side of the body.

Our patient had been in New York for some six months when she began to brood excessively over the fact that she had left her mother. She condemned herself for sinful inconsideration. Had she not vowed to her father that she would never leave her mother? Was not her mother appealing for her return? She could only blame herself. She found some solace in her room-mate, a woman a little older than she in years, but much wiser in worldly affairs.

The room-mate was not wholly androphobic (fearful of men); she met men easily in a professional setting, but they were taboo socially. She was cordial to women, helpful often to the point of embarrassing them, for she gave freely of her time, advice, and labours. No one had ever been so kind to the patient. No one had ever done so much for her, unless it was her own father. The room-mate took on the colouring of the father and thus an emotional bond was set up that was in the nature of a reconstruction of the earlier father-daughter relationship. The brooding patient was unwittingly assuming the role of her own mother, and liking it. Many little things happened around the house that evoked the expression that she was more like her mother than she ever thought she could be.

She liked her room-mate and her room-mate liked her. But the room-mate was getting a little too intimate at times, tucking her in bed, kissing her good-night.

There was something nice yet wrong about the relationship. The intimacies grew more frequent and more bold, until the room-mate became an ardent suitor. What pleasure there had been between the two began to wane, brooding was intensified, the room-mate was regarded with awe and suspicion. A defence had to be put up against the ultimate designs of the room-mate. The patient felt she was unfaithful to her mother and father, for now she was caring for, liking, perhaps loving another, a person in the form of a woman yet who was both man and woman. She was repulsed by the thought that the room-mate was the reincarnation of her parents. Earlier in their affiliations the dual role of the room-mate was quite agreeable and helpful. It attenuated the great uneasiness she had experienced upon breaking the vow with her father. But, lately—no, she did not want anything to do with the newer developments! She became ill—in the same way, without knowing it, that her mother was—paralysed on the left side. The “sickness” stopped the reproachable intimacies. Through it, also, she became as her mother and it was not long before she had the dominant role and her room-mate became the servile one.

That is the thumbnail sketch of the origin and development of a psychosomatic syndrome, behind which were the psychological details just outlined. It is the story of a twenty-eight-year-old woman who never grew away from the daughter position in life, who emotionally never knew people other than her parents. She unknowingly found herself in a homoerotic compromise, but her unconscious took her out of it by way of a physical complaint.

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Treatment of the external manifestations, namely, the "disease symptoms," was accomplished with relative ease, requiring a rather extensive survey of the foregoing facts of her life. The removal of symptoms, however, is not the removal of causes. A more lengthy series of discussion was necessary in order to free her further from her mother, to take her emotionally through childhood, through adolescence, and up through the years of her physical growth. Today she is a healthy, wholesome woman, with kindly respect for her mother, now from the vantage-point of an adult.

This is but a sample of what we called a more pronounced psychosomatic manifestation. While the physical syndrome was marked, it took but little investigation to round up a psychic syndrome that was almost as bothersome to the patient. Further investigation brought the two together without forcing any issues. Unless the parts drop in place easily, force will not put them together. In other words, do not be led into the trap of interpreting the meaning of a patient's symptoms until that meaning is already so clear to the patient that the interpretation has only didactic value. So-called interpretative analysis is only of parenthetical merit from the standpoint of treatment. Moreover, the parentheses earn the position only of a footnote. Furthermore, do not hurry to see connections between the psyche and the soma, for there is no greater therapeutic error than misleading, immature conclusions, based upon insufficient facts of the patient's life.

There is no magic to psychotherapy. There are no short cuts. The distances to be covered vary from patient to patient. Sometimes the distances are short,

perhaps of a dozen periods of review of a given life picture; sometimes the distances are marathonic and the pace must be set for a long race. But by far the majority of psychosomatic patients seen in the medical field as a whole represent neither fifty-yard dashes nor marathons, but five-mile runs. It is entirely probable that the physician will not have to give much more time, if any, to psychotherapy than he may now be giving to physical therapy to a given patient.

In the light of our present knowledge it appears that the same set of psychic troubles, the same set of emotional experiences, may lurk behind any physical syndrome. In one patient incomplete emotional growth may hide behind stomach trouble; in another it may take the form of hyperthyroidism; in a third of neuromuscular disorder; in a fourth of constipation; in a fifth of diarrhoea; in a sixth of heart trouble; in a seventh of lung trouble; in an eighth of high blood pressure. The list is a long one, but there is no evidence to date that organs of the body bear a uniform psychological response. There is a reason why this or that organ bears the brunt of an unhappy, an unadjusted personality. Often the "choice" of an organ is known to be determined by the emotional history of that organ.

Tom was brought up to worship the functioning of his brain. He was a wizard in mental operations. He showed the tendency in early infancy and it was abetted by his parents, each of whom literally took turns to store learning in his mind. The rest of his body did not learn, so to say, because it was conceived in the light of machinery designed to take the brain around the

environment. Almost all of the emotions were earmarked for cerebral use. Ordinarily this one-organed way of living is resisted by the rest of the body. Ordinarily, too, the rest of the body succeeds eventually in causing a redistribution of the emotions, even though it may have to do so through a psychosomatic complaint. In Tom's case the relative deprivation of emotions from the cerebral organ made it appear considerably impoverished, leading to headache, dizziness, perplexity, lack of concentration, and all the emptiness of living that goes with the breaking up of the personality.

In other instances a personality may have to give special consideration to some constitutional anomaly, such as excessive shortness or tallness, unusual skin pigmentation, bowlegs, enlarged head, small heart, "fallen stomach," and so on. These conditions, in and of themselves, do not give rise to abnormal psychosomatic states; that is, the mind may well compensate for the deviations of growth. When, however, the mind itself is insufficiently flexible to handle a given life situation, it may use, so to speak, an anomalous physical state as a "way out."

Henry was a shy young man who suffered intense anxiety whenever he encountered new situations. He was particularly conscious of his skinny body and he did all he could to conceal it. On the strength of a physician's certificate he was excused from gymnasium work in school; he did not play games with boys; he never went swimming. He soon came to know that intelligence was a capital asset and he built it up to full use. It served him well until he got into situations in

which it was of little help. He courted a young lady, but the courtship was the equivalent of a scholarship, which arrangement was as agreeable at the time to her as it was to him. After marriage, however, intellectual exchange fell greatly below par. Efforts to summon the emotions to complement the intelligence were almost wholly unsuccessful. The body would not respond, because for years he had divested it of emotional components. Eventually he sought the services of a physician because of sexual impotence, which was little different in principle, though greatly in effect, from his emotional and general body impotence.

Henry's mother had kept him a girl since his early infancy. He had long curls until he was nine years old. He knew how embarrassing it was, yet his mother made him feel that she was extremely proud of him. He came not to care, as he put it, what others thought. He was brought up on dolls, girl dolls; he was still playing with them at the age of seventeen, though he had to keep the practice to himself and his mother. She read him books on girls and he perpetuated the habit when he began to read.

His mother told him in all self-righteousness how bad it was to be a boy. Her creation of girlishness in him was done graciously and gently; her voice was never raised and it always appeared that she was the paragon of virtue and altruism. Indeed, while he was recounting his life history at the age of twenty-seven he told his stories in full reverence. When he was about eleven years old his mother was thinking of some reward, providing he completed two years of schoolwork in one year. He timidly suggested an electric train, though he

knew he should not have done so. All thinking was mother's prerogative. Much to his surprise and repressed glee she agreed. He completed the schoolwork and received the reward, but the train disappeared a few days later, never to return, even in conversation.

The mother made many promises she never kept, promises that would have released him in little ways from her and home. But the failure to keep a promise was never a topic for his discussion; she explained it away as a boon to him.

It developed that it had not been the physician's independent judgment that Henry should refrain from gymnasium work. The history of Henry's frailty as conceived by the mother, but not as founded on impartial facts, was the origin of the doctor's certificate. This is a form of illusion not at all rare in the parental mind. In a subtle manner, replete with sincerity, a healthy child can be made to look moribund. The doctor who does not fall in easily with the conspiracy is simply guilty of misguided judgment. With a little more effort, the doctor with the "correct" point of view is found.

Henry's total life was impotent, save for his intellectual career. That was potent enough—like a new car fully equipped, but without transmission gears. When he appeared for examination and treatment, he placed almost exclusive emphasis upon his frail physique. The rest of him, the part that made him or should have made him a human being, was completely unimportant to him for a long time. He reviewed his life because he was asked to do so, yet it was some time before he began to wonder why the physician went into such

details. He had early been told that all physical tests were negative, that he was thin, to be sure, but not weak or frail. That was his mother's diagnosis. His strength had never been tested. Slowly, very slowly, he came to see himself as others saw him. He is not a robust fellow, but he is not afraid to be a man.

It was as difficult to keep the mother from interfering with treatment as it was to encourage the son to take it. It was she who took the boy, or, rather, the married man, to the doctor, to whom she recounted his past weaknesses. It was she who corrected him every now and then while the initial history was being taken. She said he began to get "really" sick when he married, that is, when he left her. But he never left her; she never left him. She merely acquired an additional child in the legal garb of a daughter-in-law.

Henry's problem was an anomalous physique, but one which a substantial mind could have put to good and reasonable service. His body bent to his emotions; the reverse should have happened, under appropriate conditions, to ensure equilibrium.

It is evident that the mind may use a healthy physique to convey its message of distraction; or it may seek outlet through anomalous physical states. Still further, it may conceal itself most effectually through recognizable conditions of physical disease. The troubled mind is impartial to the state in which it finds an organ. When organic pathology is present a mental conflict may seek refuge in it and use the organ for the greatest possible personal gain.

As a rule there is little immediate reason for ferreting out the unhealthy psychology behind an organic

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disease giving rise to disabling symptoms. Of course, a sound mind does not look for scapegoats. And there are many minds that are unstable only in the presence of a tangible organic disease process. It is as though the otherwise stable mind takes advantage of the opportunity to "unload" itself on a passing condition. Some people are peevish, childish, impatient and have to be babied over a toothache or a cold or a sprain. Others get tense, nervous, fearful, and believe that the illness marks the beginning of some terrible disease, from which recovery may not take place, or if it does there may be permanent harm.

Society accepts regression to babyhood as almost a natural accompaniment of organic disease among certain types of individuals, because it knows that when the organic pathology clears up, the psychopathology goes with it. The patient may unwittingly, sometimes wittingly, continue with the organic symptoms long after tissue structure and function have been restored to normal conditions. The symptoms continue to serve as a shield for the unsound mental state. This situation is well exemplified in that large group of disorders known as the compensation neuroses, in which it is financially in the interest of the patients to continue to remain on the payroll without working. These are the people whose adjustments to work are tenuous long before some physical mishap overtakes them.

When the symptoms of a physical illness extend obviously beyond the restoration of the tissue to a normal healthy state or to a state which though permanent is not as severely disabling as the patient indicates it is, then it is time to look to the personality

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for further remedial measures. This is true no matter what the nature of the organic disease process may be. When there is psychopathology waiting for some organ through which it can express itself—unless there is one already prepared in the past for the receptivity of the psychopathology—any kind of sickness in any organ or organic system may serve as the convenient vehicle. Thus the latter may be in the head, any of the sensory nerves, heart, lungs, stomach, intestines, rectum, skin, muscles, nerves, and so on. As stated before, there is no special psychopathology for any of the tissues of the body, but there is psychopathology, peculiar to the given individual, that may invade any tissue.

IX

ILLNESS AS A DEFENCE AGAINST HOMOSEXUALITY

NORMALLY the child begins the long trek to psycho-biological maturity at birth, conditioning and deconditioning himself from one set of conditions after another, always retaining some features of each in sublimated form. It has been seen that he remains a vegetative, instinctual body for a time. He is gently transferred from that type of existence to a state in which he gains knowledge of his body, the education coming from the parents, especially the mother. The training of the body gradually passes from the parent to the child, starting with training of the child as a static being, so to say, and progressing to education of the child as a moving object. All of this is a slow process, for the child first moves as an extension of the mother (or father); later he moves under his own momentum. His range of activities likewise expands slowly, from the crib to the play pen to the floor of the nursery to the living-room, dining-room, yard, street, neighbourhood and beyond in ever-increasing circles.

In earlier chapters we showed how steadily the normal child grows from body-mindedness to mind-mindedness, to parent-mindedness, to teacher-mindedness. Then we stopped to view some of the pitfalls of growth from the standpoint of psychosomatic medicine.

During these early years the child becomes aware of gender; he identifies himself with both the mother

and the father; growing away from his biologically bigenderistic status, he acquires psychological bigenderism in the form of his parents. In the normal child the bigenderism steadily gives way to unigenderism.

The steps taken to gain the stage of one gender are slow and easy to negotiate for the healthy child, although even for him there must often be judicious guidance. At about the age of four or five the child begins to affiliate some of his (or her) interests in members of his own gender. The term *suigenderism*, of one's own gender, is used to prescribe this phase of growth. The boy dresses like a boy, acts like a boy, plays with boys' toys and games, wants to be like his father, to wear long trousers, put on a shirt and necktie, jingle a few coins in his pocket. He emulates others for several years. Gender is thoroughly impressed upon him.

Why does a man have to exert such great effort over so long a period of time to ensure that he acts and lives in accordance with his physical set-up? The need to genderize man in his or her appropriate biological channel for so long a preparatory period must arise out of the uncertainty of the results of a short training period. Man does not become capable of sexual reproduction until puberty. It takes years to make a man a man, a woman a woman. Nature takes from twelve to thirteen years to do it and our society, doubtful of nature's schooling methods, adds at least a half-dozen more years. In a large number of instances the parents add another half-dozen for good measure. Bigenderism and bisexuality are a problem in human evolution, in the evolution of the given person. It should not be surprising to anyone that with such intensive training, a

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certain number of individuals try to get along in life with the facility they know best.

From the stage of genderism the normal child passes imperceptibly into that of sexuality, gaining experiences in the latter largely through activities with members of his own gender. He chums with boys, compares his body structure with theirs, plays with them, learns from them what he dare not learn from his parents, confides in them what he cannot confide in his parents, studies with them, stays overnight with them. In other words, boys become his emotional objectives, drawing a fair part of the emotions formerly allotted to the parents. Girls come in for some minor consideration in the nature of investigation but not pursuit.

When the average boy comes into manhood he takes the secret to his boy friends, but for this issue the members taken into this secret are carefully chosen. Indeed, often he falls back exclusively upon himself. Often, too, for a short period he engages in mutual play with a friend or two. Then he branches out carefully, fearfully to the other gender, and finally to her as the other sex.

There are, of course, many variations to the sketch just given, variations that fall within the range of average, healthy psychosexual growth. The deviations that are outside the normal range constitute our chief interests, more particularly those that give rise to psychosomatic complaints. Before describing the latter, however, it may be mentioned that there are several steps between suigenderism and the assumption of the husband and father role.

The youngster progresses as a rule from his own

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gender (suigenderism) to his own sex (suisexuality or suigenitality), whence he branches out to the gender and sex of members of his kind. It is said that he in part "projects" his interests from his own self onto others, that the aim, male attributes, remains the same, but the object changes. A certain number of individuals, both male and female, find their only sexual gratification among members of their own gender. They are the true homosexuals in the sense that they are as completely contented with homosexual love as is the masculine male with heterosexuality or love for the opposite gender. They are as averse to the other gender as a man may be to loving a man.

It is known that the homosexualist is decidedly so on the psychological side. Whether there is any correspondence is important for the overt homosexualist, for he loves a man, she loves a woman and the problem rests there as far as the individual is concerned.

Because there is no mental conflict in the overt, well-established homosexualist, until or lest he loses his "sweetheart," psychosomatic problems on the basis of homosexuality are remarkably rare, as unusual, indeed, as they are among men and women who are happily attuned to affiliations with the opposite gender.

It is the repressed homosexualist, sometimes the suppressed, who often encounters psychosomatic difficulties. Repression implies the presence of the tendency in the field of the unconscious and outside of the knowledge of the individual. Suppression denotes the conscious and wilful aversion to the impulse.

It should be noted, too, that there are two general

routes over which repressed homosexuality may pass to gain outlet from the unconscious. Both are used with about the same frequency. The same individual may employ both at one or at different times. The one is the mental route of expression, that is, the repressed homosexuality appears in the form of ideas and their accompanying feelings; but the ideas are disguised, so that neither the patient nor others can detect their homosexual nature. This is accomplished, for example, in the paranoid individual when he projects the homosexuality upon another man or other men. He believes that men are trying to degrade him, to demoralize him; they treat him contemptuously, as if he were a degenerate; they show their disgust through their unfriendly attitude toward him; they spit in his presence to make their point clear.

This way of handling the homosexual issue merely gives objectivity to the issue. In this form it does not comprise a psychosomatic problem.

There is a second route of projection, so to speak, the physical. Scientifically it is not known as projection but as a form of conversion. The homosexuality drains from the unconscious into one or more organs of the body, again in disguise, but this time as physical symptoms. This is another true manifestation of psychosomatic disorder. It is not uncommonly seen in the general practice of medicine and the nature of the symptoms is often, though by no means exclusively, like those that arise when other unconscious forces, for instance, narcissism, the Oedipus complex, are activated into unnatural symptoms.

There is at least one general principle that pervades

the general run of psychosomatic symptoms stemming from repressed homosexuality. It is the feeling that some function has been lost. The function may be that of appetite, digestion, elimination, motility, thinking, and so on. All physical tests are negative, yet the feeling of deprivation persists unabated. Indeed, it is not at all uncommon for these individuals to pick up enough symptoms in office conversations to "feign" a concrete disorder, for which they insist upon some surgical operation, requiring removal of some part of the body—tonsils, deviated nasal septum (this is a favourite dislocation of the real source of the trouble), appendix, some alleged tumorous growth, and so on. Surgeons know too well how often the removal of a part removes only the part, leaving the symptoms unchanged, year in and year out.

If the function has been lost and if that function is but homosexuality in disguise, why do the patients want it removed? Because they never wanted it in the first place; they repressed it as an unwelcome urge. And they do not like it any better in the guise of innocent symptoms, for they are still as tormented as if they were faced with the original source of the trouble.

The sense organs, particularly the eyes and the nose, are remarkable substitutes for sexual functions. It is generally known how influential sight and smell are in sexuality. They are biologically rooted in almost all forms of animal life and they are no less important in principle to man than they are to the lower animals. As an indication of the primary role that the eyes, for instance, may achieve in sexuality, it may be mentioned

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that some individuals gain major sexual satisfactions simply by looking at the genitals of others. Peeping Toms are well-known examples.

Not a few repressed homosexuals actively avoid looking at members of their own gender. Many express the idea that they may seem to be looking at the pubic region. When the idea of looking at men becomes repulsive to the man who looks, he may begin to complain of eye trouble, of weakness of the eyes. Not infrequently he avoids social gatherings because the eyes hurt. He cannot go swimming because of the glare of the beach, and the water of indoor pools causes inflammation of the eyes. Ophthalmologists are familiar with the patient who complains bitterly about his eyes, yet in whom nothing of a physically pathological character can be determined. Often the problem is genuinely of a psychopathological nature.

A patient who had been seen by a number of ophthalmologists over a period of a few years was finally seen by a psychiatrist. All the while he was being examined by the ophthalmologists he knew that he had anxiety attacks whenever he faced a man, attacks due to the fact that he could not successfully avoid looking at the man's private region. He never mentioned that fact to any of the eye men, first, because he thought it was not connected with his eye complaints, second, because the eye men never asked about *him*, only about his eye complaints. They all noticed a peculiar nystagmoid movement, but it baffled them. He knew well that his eyes jerked away from men, then back to them, but he never offered an opinion.

The nystagmoid movements, it developed from the

history, were first noticed when he was taking a shower in a gymnasium while other men were also taking theirs. At the time, he was ashamed because he was aroused sexually by the sight of the men and he completed his bath hurriedly.

The fear of looking and the fear of being looked at were but an acute and different manifestation of an uneasiness he had constantly experienced while with boys and men. Indeed, he was usually mute or monosyllabic or he half stuttered in their presence, for he was certain he would say something wrong, something they would not like. Moreover, for years he had the habit of backing away from people while in conversation with them, in a kind of swaying motion, to and fro.

The ocular, oral, and general motor activities were due to the same source, for they occurred only with men, were absent when he was alone, and did not occur with girls, principally because he was seldom with girls, except on business occasions. His hobby, as he put it, was to seek comfort in conversation with women far older than himself. The symptoms never appeared while he was with the older women, the motherly kind, toward whom he acted as a boy.

The ophthalmologists noticed how nervous he was, how his head jerked to one side, his eyes too. Besides, he drew back at the same time as though he were afraid. The physicians had some difficulty in completing their examinations.

The psychiatrist simply took a history of the ocular difficulties, though he investigated at the same time the man who had the eyes. It was not long before the

dark glasses, worn for several years, became unnecessary, for the patient himself soon saw the connection between his eyes and men.

This kind of examination involves no theories about eyes or about any part of the body. There is nothing mysterious or magical about the procedure; it is simple history-taking, employs ordinary, everyday conversation, and the patient, not the doctor, establishes the relationship between the psyche and the soma. The physician should be without prejudice in his examinations; he should not steer the patient to his preconceived notion, which, however, he has a right to have. Without a knowledge of the possible causes giving rise to a physical complaint the physician is inadequately prepared to examine the patient. Investigation of the individual having the local disorder often gives fruitful clues to causative factors.

Psychotherapy of the ocular patient in question involved him as a man, a human being, who never outgrew his boyhood. Indeed, he was more of a son in his adulthood than anything else. He never acquired easy companionship with boys or girls and it was evident that he was stalled emotionally in life between his parents and extrafamilial associations. The prescription in his case was to grow up, starting essentially a little before puberty and educating his emotions gradually to the succeeding years.

For those who look carefully into the lives of their patients, it will not be without significance that the patient tried to socialize his human difficulties by becoming a photographer. He was never wholly at ease with the profession. Later he earned his livelihood,

small as it was, in television. He is now a capable salesman of non-optical goods.

A young lady was never without dark glasses, save when she was in more or less total darkness. Frequent examinations of the physical structure of the eyes were without consequence as to cause. She was a shy girl, though very flirtatious and coquettish, dressed to attract admiration, but frigid to personal comments from those who would seek her companionship. The patient herself soon gave the information that her amorous triflings were not designed to attract men but rather to gain the esteem and adulation of women who noticed how the men grouped about her. Her women friends liked her exceedingly well, because after all "for some strange reason" she was not a competitor for masculine attention. Her friends knew her as a girl's girl. She spent long hours with girls, outwardly unaffected by their clothes yet secretly thrilled by their more intimate attire. Indeed, only she knew that she was sexually aroused by the otherwise innocent display of clothes.

Clothes, other girls' clothes, were her fetish and she loved them as a suitor might love his sweetheart's handkerchief. Her friends knew it was an act not to be questioned in any ulterior way when she borrowed this or that article to wear. But the patient knew the real reason for the attention she gave to other girls' possessions.

She was a modest girl, but with the years her impulses belied her modesty, not that they ever were guessed by others, though keenly felt by her. When did she start to wear dark glasses? About two years previously. She remembered that her eyes began to hurt while she was

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vacationing with a girl whose friendship had only recently been established. The girl was very much like herself, shy, attractive, fond of clothes, disinterested in men, but liked to draw nice comments from them about her station, posture, and fine taste in clothes. They were happy vacation partners, until both sensed that their interest in each other was taking a more intimate turn. Veiled references to their finely modelled bodies gave way to closer scrutiny under the pretence of trying on articles of clothing.

The patient was becoming ill and listless; she lost appetite and suffered from insomnia. In seeking a reason she was sure she had been on the beach too much; the sun and the salt air had affected her in general she reasoned, but her eyes bothered her most. Though there was no local evidence of eye trouble she took to wearing dark glasses all the time, indoors, outdoors, daytime, night-time. It seemed very plausible for a long time, but the symptoms, all of them, carried over into the winter months. She converged her interests upon the symptoms, abandoning her liking for clothes, and saw her girl friends infrequently. Usually they visited her as a sick girl.

She knew what the cause was, but did not know. It could only have been the weather elements, she said to herself, yet she had often spent vacations on the beach without such consequences. All manner of physical tests were negative. The ophthalmologist could find no cause for the ocular complaints. When the foregoing events were reviewed with her, but in far greater detail, she was intensely emotional, earning the family's diagnosis of hysteria. They were not wrong.

She was a pampered girl, they said, always had been, and in a nice sort of way she learned how to gain the centre of attraction and hold it. She was a family girl. That characterization had often been a topic of discussion, mixed with admiration but also with the wish that she might widen her friendships to include eligible young men. The parents frequently hoped that she would grow less dependent upon them, but she was twenty-four years old now and still without beaux. They used to mention that fact to her, hoping she would enlarge upon the topic. She would gaily toss it off.

Discussion of these and allied themes on her growth as a human being gradually gave her insight into herself, but not into her symptoms until some time later. Gradually her horizon widened; she returned to her girl friends and branched out into companionship with men of her age. She is now married happily, has a little girl upon whom she now bestows the love of clothes, this time in an entirely reasonable way.

More intense psychosomatic involvement of the eyes is not uncommon. The most extreme examples are witnessed in many of those individuals classed as having schizophrenia or dementia praecox.

A young man, twenty-two years old, had always been quiet, reserved, shut-in, courteous when addressed but offered very little in the nature of conversation. Since early boyhood he had devoted himself to scholarship and the piano, both interests comprising his main sources of outlet. Friends recognized that the human elements were missing in him, or at least that they seldom appeared. His Gordian knot was himself; he tried to unbind himself from himself but was able to

gain very little freedom. He established a few contacts with boys of his age, but they, too, were musicians and their associations were more or less impersonal.

The boy was highly moral and ethical. When he came into puberty and the nature in him made itself known he recoiled with disgust. He quietly withdrew from his mother, to whom he had been ardently attached, and allied himself more closely with his father. The parents knew that he was too narrow in his experiences, but they felt that after he had completed his musical education he would widen his field of activities.

He had had some minor experiences with boys of his age, yet to him they were not minor. He worried considerably because he regarded them as immoral. He soon found himself beset with obsessive ideas relating to sexual play with boys. These thoughts intruded upon his faultless conscience, besieged him, made him panicky; he tried violently to shake them off, but he could never get rid of them. He succeeded in totally disregarding his genitals, producing a state of genuine psychological castration. But the images of homosexuality relentlessly forced themselves upon him. He tried valiantly to shut them from his mind, shut them from his eyes, but they would not leave.

He began literally to fight his eyes with his hands: he actually blackened them through punching; often he thought of having them enucleated; he rubbed them to the point of extreme inflammation. Ophthalmologists recognized clearly the pathological psychology involved in the eyes and in the whole person, yet they, as well as the psychiatrists who were called in, were helpless to effect a change.

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The boy made ineffectual efforts to castrate himself and to remove his eyeballs. He finally "solved" his problems by going into a state of complete immobility of mind and body, into what is called a state of catatonic stupor. He never recovered.

These few examples of psychosomatic pathology are related to indicate that repressed homosexuality that demands outward recognition may be lived out, so to say, through the eyes. The homosexual impulses which acquire morbidity to these individuals are transferred almost *in toto* to the ocular apparatus, the eyes, serving as the focal point upon which the errors of the personality converge.

When treatment is possible and applicable it is directed toward a construction and reconstruction of the human elements that have been missing or faulty. With growth through appropriate channels of living the inordinate quality of energy crammed into a local bodily zone is disseminated through healthy environmental attachments. The details of psychotherapy are discussed in a separate chapter.

It may be mentioned here that while a psychosomatic disturbance may stem pre-eminently from one or another zone of psychopathology, say from homosexuality, it rarely happens that a solution of the homosexual issue is sufficient to effect a cure. This is so because the various parts of the mind are not arbitrarily delimited, are not pigeonholed; they are intimate parts of the experiences from which they emanate and to which they give rise. Hence in the therapy of psychosomatic disorders it is highly essential that not only the nucleus be treated but that more or

less immediate surrounding elements also be given consideration.

The nose is well endowed with psychic components. The cartoonist is familiar with the value of the nose as a vehicle for the expression of character traits and moods. The rhinologist is richly aware of the emotional value of the nose. He appreciates that it has aesthetic worth, that its size and shape are often of great importance to the individual, and that anatomically and physiologically it participates, with its erectile tissue, in sexuality.

The part that is emphasized here, however, is restricted to psychosomatic considerations that have medical bearing on issues for which the patient seeks relief in the physician's surgery. More specifically, in this chapter stress is placed upon the part the nose plays in the vicarious expression of repressed homosexual impulses. This does not mean that only homosexual trends may find expression through nasal symptoms, because that is not true.

There are patients, for instance, who are very ashamed of their nose and long for some way to conceal it. They blush easily when the nose is mentioned or when references are made to odours, this in spite of the fact that anatomically and functionally the nose meets good requirements. Usually these people complain that the nose is always running or that they have postnasal drip and that the membranes seem always to be swollen and stimulated. When examination fails to reveal any positive evidence by which to support the complaints and particularly when the complaints last for a long time, it is desirable to look into the personality for a

possible cause. It is not at all unlikely that there may be a sexual problem of such severity that the patient has transferred it to the nasal region. It is realized how far fetched this suggestion may seem to some, yet when the patients themselves ascribe to the nose symptoms that are identical with those they had given to the genitals and when, moreover, as often happens, the nasal symptoms quickly disappear with that understanding, some validity must be given to the relationship.

The patient understands when he is asked if he had ever experienced a similar set of symptoms, namely, shame, concealment, easy blushing, disgust with disagreeable odours, over-stimulation, and swelling. No interpretation is necessary or desirable. There is no need to resort to hypotheses. The patient knows, though he may not at first tell you he knows. Nor may he tell you until later that because of his troublesome nose he has been inactive "down below." It is not an unrelated duad that under special conditions and in the right type of personality nasal activity and sexual inactivity coexist, with the symptoms of the former the same as those of the latter. It happens too frequently to be charged to chance. While not restricted to a masturbatory complex, the duad is often traceable to it in both men and women. With the proper psychological approach and the proper setting any physician should be able to check on the validity of this concept. It would be a mistake for the physician to offer the interpretation to the patient with or without adequate facts. It would be appropriate if he merely presented again to the patient a full account of the facts gained

from the patient, just about as the latter had given them.

A twenty-one-year-old girl was the youngest of a family of four children, the first three of whom were boys, much to the gratification of the father. He was the leader of the family; his word was law; he did not like women and he treated his wife as a mistress and housewife. Whatever she did for the children was first submitted for his review. He dictated the care of the children from their early infancy onward. He was the mother of the family by his own choice.

It was a great disappointment to him when the girl was born and he never ceased carping on the subject. But he did not neglect her. He gave her much attention, of which she in her early years was particularly fond. With great kindness he treated her like a boy, urging her to do better than her brothers were doing in sports, school, and other general activities. "She" was his favourite; he gave "her" more attention than he had given to any of the three boys. He repeatedly compared her successes to the relative inadequacies of her brothers. She could do better at her age than they could. She was more active physically; her timing sense was superior; she could hit an object more often than they could. Later she was praised for her marksmanship. She was a better mathematician, had a better mechanical sense—she was just a little better in all departments. What he did not take time to know, or to care about, was that she was being trained to be a better man than men.

She was unfamiliar with any references on his part to femininity, though he never discouraged feminine attire. The topic was simply not mentioned.

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The children grew up through him, not through themselves. The boys were "without character," though they learned well how to be obsequious to the father and dictatorial to others. Likewise the girl's personality was avalanched by the father. Through training she grew into manhood, entered what is commonly believed to be a man's field and earned the constant praise of her father. Nevertheless over the years there was a hidden yearning to be a girl, to do things that girls do. Outwardly she was an attractive girl. Inwardly she was her father.

He died when she was seventeen years old. She thought it odd that she did not mourn what should have been a grievous loss. She remembered that she had had to pretend grief. He had trained her well and she had no difficulty pretending. Shortly thereafter she precipitously gave up her manly pursuits and tried to act as she had seen girls act.

The conflict was despairing. The inside man was stronger than the outside girl. Compromises between the two led to bewilderment, discouragement, and hopelessness. She likened herself to two people in one, each trying to go in an opposite direction. She did not know which way to turn. Finally she developed a physical symptom, incessant blowing of the nose. She blew when there was nothing to blow, because she felt that something had to come out.

The best rhinologists gave her a clean bill of nasal health and could find no organic reason for the perpetual nose-blowing. In the consulting room of the psychiatrist, examination of her past and present experiences was carried out via paper handkerchiefs. It was noticed that she was very irritable with her nose,

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complaining to it as if it were another person, cajoling it, censoring it, threatening to have it cut off. It was so troublesome, she explained, that she was certain she would get along better with just a hole there. She added that it curtailed all her activities. Her boy friends gave her up because the handkerchief got more attention than they did.

After long discussion, during which she was becoming emotionally emancipated from her father and the father role, she eventually uncovered a long-lost memory. When she was five or six years old, she recalled, she used to think it was not right that her father should like her to be a boy. She was not a boy; she was a girl. She laughingly told herself that the only resemblance she had to a boy was her nose. She knew then that she referred to the male parts. But the thought of being a girl was unholy, sacrilegious to her. She blamed herself for disobedience to the father and vowed never to think of the subject again.

It was not long after the unconscious value she gave to her nose was rediscovered during psychotherapy that the nasal symptoms began to disappear. But that was only one of hundreds of ideas that had to be treated before she moved about as a girl. To be sure, it was the most troublesome symptom; still, it was only symptomatic of a wide series of circumstances that made her both a man and a woman, but neither. It bears repetition to emphasize that psychosomatic symptoms are but the obvious evidences of a disturbed, distraught mind. A psychosomatic symptom is like the part of the iceberg seen above the water's level; it is but the top of a far larger structure.

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Psychosomatic symptoms, homosexually determined, may appear in various other parts of the body. The throat is not infrequently an emotional problem. Among psychogenic symptoms of this region may be mentioned chronic "cough," clearing of the throat, the sensation of constriction, gagging, the feeling that a foreign body is lodged in it. The general idea is that something has to be removed from the throat. In these instances the commonest etiologic agent is the dual impulse to accept and reject orally at the same time the male organ, less frequently the female genitalia. The oral incorporation of the former (fellatio) and of the latter (cunnilinctus) comes from the primitive part of the unconscious; it is reinforced by the early habits of infancy when the mouth for a long time is the pre-eminent part of the body to come into contact with environment. The infant touches everything he can with the mouth.

Some people are notably oralists, so to speak. They may have remained at the breast for an unduly long period of months, even years. On the other hand, they may not have been breast fed. The fact is that for some reason or reasons not fully established, the oral zone seems to be over-endowed with the need for stimulation. Certain patients give a history of prolonged breast feeding or of staying at the breast for months after it has lost its nutritional value. It is obvious in many instances that the child remains at the breast for emotional reasons.

In the succeeding years these children come to be known to their family and friends for their oral habits. Some are known as mouthy. De Quincey spoke of "a

turgid style of mouthy grandiloquence." These individuals always have a mouthful of something—words or food. They express impatience or resentment when the breast of words or food is taken from them. This is not theory. We all meet people with whom we "can't get a word in edgewise." The physician encounters the patient who is loquacious throughout the examination period. He attends medical meetings that threaten to go on to the breakfast hour. The mouth is a small part of the body and too often its needs for stimulation are insatiable.

A young lady was troubled with indigestion, for which the doctor prescribed. She knowingly held back the information that she ate voraciously several times a day when she was not the least bit hungry. She had no knowledge of the real reason for the ravenous eating. Investigation revealed that eating was genuinely an oral pleasure that traced back as far as she could remember. She was sure the cure of the indigestion, if it meant the curtailment of excessive eating, would be ineffectual. She was an unattractive girl because of her weight, was not interested in boys and had few girl friends. In later interviews it was determined that she had always longed to be as fat as her father, for she was devoted to him. There was much additional information on the emotional urge of the girl to identify herself with her father.

There are other instances in which patients eat so little as to reach the point of starvation. Some patients with the diagnosis of anorexia nervosa, mental loss of appetite, are of this type. They weigh their food in grams and eat most sparingly. Not uncommonly they create great hostility in the home, with particular

reference to the mother. In their total behaviour in life they are often misanthropes, showing their animosity in all areas of living. They act like children who want mother to know fully what they eat, yet resent bitterly any attention she may give to the problem.

Throat symptoms on a homosexual basis may take the form of the almost intolerable sensation of constriction. While this symptom is not limited to any diagnostic group, it is not rare among patients with conversion hysteria, with globus hystericus (hysterical ball) as the central phenomenon, and those of the paranoid form of schizophrenia. In both instances there is a well-developed homosexual component which expresses itself in the throat as well as in the other parts of the body. The laryngeal anaesthesia of the hysterical individual is well known. But the hypersensitivity accompanying globus hystericus is no less well known. Nor is the delusion of food poisoning, related by the paranoid patient, of lesser significance, for he feels that his enemies poison his food with dirty, scummy material with the purpose of degrading him.

Many people strive diligently to find their sexual position in life, especially their psychological sexual position. The problem may dog them for years and become so perplexing as to cause them to act at times like a man, at other times like a woman, and again like a member of the neuter gender. It appears that the shifting from one to another is a reflection of the instability of sexuality from the biological point of view. It is not unlikely that the biological instability may facilitate the great influence that parents can bring to bear upon the type of sexual preponderance appearing

in their children. It is not difficult to change a male child to a psychological female, or a female child to a psychological male. It is an age-old process, exemplified not alone in the so-called medical problems we treat but also permeating our literature. The poets wrote of the miraculous transmutation of a person or animal into a different and frequently antagonistic or contrasting form, either with or without a corresponding change of nature. We recognize it as psychological metamorphosis.

Such metamorphosis is common to human beings. It usually falls within the range of normal living, or at least of average living. It may not give rise to any essential difficulty, but there are many people who are rendered so miserable by the contrasting natures in them that they fall sick of some "disease," some emotional disease, mild in some instances, grave in others, with all manner of intervening states. Many psychosomatic disorders represent the resultant of the mental conflict associated with psychological bisexuality.

When the conflict is intense in a person, he may attempt to make his psychological maleness correspond with his physical maleness. Not a few marriages are based upon this attempt, which may be successful or unsuccessful in varying degrees. Man is, as Adolf Meyer puts it, an experiment of nature.

X

MARRIAGE AS A CURE FOR SICKNESS

PSYCHOSOMATIC issues requiring medical attention are frequently set in motion as a consequence of factors arising from married life. The average well-adjusted couple share the responsibilities attendant upon the state of marriage, the man assuming those duties that society tacitly expects him to bear, the woman hers. Usually there is a harmonious mixing of prerogatives.

Many marriages, however, are not consummated on the basis of sharing. This is especially true when one or both parties are unprepared by training, experience, and endowment to give as much to the common pool as they might be expected to give. Shakespeare spoke of the "marriage of true minds." It is that type of marriage that leads to harmony—and, more pertinent to the point of this chapter, to psychosomatic harmony. As valuable as property may be, as helpful as it may be as an adjunct to happiness, it can never act as an appropriate substitute for the emotions.

It is an odd commentary on human nature that while all recognize that marital unhappiness can give origin to physical tiredness, fatigue, loss of appetite, insomnia, disordered concentration, dizziness, and a host of other symptoms, we assume that it happens to the other fellow but not to us. Time and again a patient wrecked on the marital shores is offended when that idea is presented to him; and his wife violently objects to any such opinion by the physician.

A patient, forty-two years old and married for twenty

years, walked slowly and hopelessly into the physician's surgery. His face was drawn and pale; he spoke in a low voice; the enthusiasm for living was gone; he had lost considerable weight and had no zest for eating; he was always tired, but sleepless; he had constant, dull headaches. He was a sick man. All physical examinations were inconsequential from the standpoint of determining the cause of his illness. He and his wife could offer no suggestions. During the first several interviews he could do little more than recount his symptoms.

He offered a few "irrelevant" remarks in the nature of "asides." For instance, each time he returned home from the physician's surgery his wife insisted that he tell her in detail what was discussed in the surgery. He looked upon her demand for details as an annoyance, but charged it to her concern about his health. On another occasion she asked if the doctor had said anything about her. Again, she took him on long and weary shopping tours while he was in the city. She literally dragged him through museums and churches, for this was an occasion, too, for seeing the sights. All the time he was bedraggled. Within two weeks they had seen all of the theatre that she wanted to see.

Though their hotel was twenty minutes from the physician's surgery, she never went there. Instead, after her husband went to bed, she wrote letters, ten to fifteen pages in length, to the physician, announcing in a none too subtle manner her undivided love for her husband. In the meantime the patient graciously mentioned to the physician that though he could not sleep, the nights were made worse because she kept the lights

on through her hours of writing. He feebly protested when he later found out that the very first day of their arrival in town she had wired his secretary to send a copy of his will and all his insurance policies to her.

While this story is being related it should be known that he described his wife as a kindly soul; he dismissed as unimportant the tourist nature of her visits to the city; he pardoned her for her multiplicity of interests. "It isn't even worth mentioning. I guess I'm an ingrate." He recounted evidences of her fine character, her stability, her helpfulness to him throughout their married life. All of this "whitewashing" stood out in bold contrast to the facts he later gave to show that he had been a sacrifice to life as long as he could remember.

Sacrifice was the pattern of his existence. He grew up with it; he belaboured himself throughout boyhood and adolescence. He was a moral masochist, growing fat on unhappiness, so to speak. In his early years suffering was a consecratory rite; he did perpetual penance at the altar of his mother. Like so many people whose early habits are deeply ingrained, he carried those habits stoically through courtship and marriage. He married the dispositional image of his mother.

His mother and wife were interchangeable. His wife needed a son, he needed a mother. Their marriage and married life were consummated almost exclusively in accordance with the unconscious impulses of both parties. They lived without conscious judgments, which is but another way of saying that they were not entities in themselves. They moved on the emotional momentum provided by their parents. This is not to say, however, that they lived happily, because they did not—

for years they buried their conflicts in nice-sounding phrases. Every now and then their unison was exploded by the wrong admixture of words and feelings. The damage was repaired with synthetic words. Over the years their personalities became pockmarked with the scars of hostility.

His sickness, organically presented, was the outcome of his childish ways of living. He succumbed to the internal pressure, to the damning up of aggression, of sadism. She did not obstruct her feeling life to the extent of inducing a neurosis. Indeed, she profited emotionally by his discomfiture, for in the guise of helpfulness she led him more deeply into his neurosis. Without knowing it, he praised her sadism, while he reasoned that his illness was organically determined.

It was a relatively long time before the patient could peel off the false layer of admiration for his wife and thus expose the real underlying feelings towards her. Nor was it any easier for her to understand the part she had always played in his and her own life. Basically both were honest, honourable people, without conscious intent to hurt each other. When they were shown that the purpose in understanding themselves was to create sound and wholesome relationships they began to see themselves as they were underneath the guise of harmony. The function of treatment was to bring them together. Legal separation should be the last resort and should not be considered until psychotherapy has been given a thorough trial. This is especially true when the couple have lived together for years, because that fact in itself almost always means that there have been many valuable features that have held them together so long.

Unless they had a sense of responsibility toward one another they never would have remained together that long. Moreover, the fact that one of the members had to resort to a psychosomatic syndrome in order to ease his conscience, while trying to evade the other member, is a clue to the aim of therapy, namely, to keep them together. It is easy to recommend separation. Physical separation, however, does not alter the fundamental conflict in the personality; it simply moves it geographically.

Most marital troubles are not basically due to marriage or to the immediate events in marriage. They are representative, rather, of the constitutional tendencies of the parties, tendencies having their origin and development in the years before marriage. That is why so very few psychosomatic issues seen in a marital setting, presumably arising from it, are essentially uninfluenced by treatment of the more direct marital situations alone. The latter must be managed, but for best results the factors giving rise to the kind of person found in marriage must be treated. *The psychosomatic problems of marriage are most frequently the end results of a long series of personality reactions, brought into a stage of acuteness by the marriage.* This point of view is emphasized in order that a more comprehensive, and therefore a more influential, therapeutic position be taken by the physician and the parties involved.

Marriage or the married state is not *per se* a noxious agent. The uses to which it is put, however, are often deleterious. It is our immediate purpose to survey the role that psychosomatic medical issues play from the standpoint of marriage.

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Marriage may be the scapegoat upon which the "sins" of the past are placed, after which the goat is driven into the wilderness. The troubles of the past that seek solace in marriage are many and varied.

Among the leading impulses that take one into marriage is an inordinate dependence upon one's parents, a childlike subordination that is recognized by the individual as inappropriate and unwholesome. It represents a perpetuation of the Oedipus complex that should have trailed off perhaps years before. A not uncommon outcome of an unusually strong Oedipus leaning is the kind of marriage that does not change the leaning in any substantial way; it changes only the characters in the marriage, not the characteristics.

A man of thirty-eight appeared in the physician's surgery with complaints of fatigue, great weariness, stomach trouble in the nature of pains and indigestion, loss of interest in people and things, and a peculiar head sensation, described as moving clouds. He feared he was through with life, expressed the opinion that his body had worn out prematurely on the basis of hardening of the arteries. His whole being left empty. Organic causes were not found after exhaustive examinations.

From early boyhood he had been reared by a temperamental mother who was at once kind and severe to him. Sometimes she showered him with praise, rewarding him liberally for some minor act of obedience. At other times she beat him physically until he bled, then locked him in a closet for hours. This form of conduct lasted throughout his boyhood and into the first half of adolescence. It was obvious that the boy

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made no great effort to avoid penalties; on the contrary, knowing that the punishment would be severe, he often intentionally created situations that he knew would lead to severity. He did not dislike the role of masochism. Indeed, as he put it, he never received any affection from his mother until he had first been punished. Punishment and reward, in that order, were a ritual.

He had two older sisters whom he constantly teased and from whom he received intense beatings. In fact, his formula for living was hurtfulness at the hands of women. The three—mother and two sisters—not infrequently ganged up on him in a body, a *mêlée* lasting an hour or so, the scene shifting from room to room. It was his favourite move to crawl under a bed, from which position he could fend off the opposition for a long time, while they poked and reached for him or shifted the bed from one location to another. When finally he was openly available for direct assault the women had spent so much energy getting at him that the last round was relatively tame. He was proud to consider himself the victor under such circumstances.

The women of the house hated men. The mother had married not out of love but out of the desire to have girl babies. Her interests were fulfilled when the first two babies were girls. Her husband was simply an expediency. After performing his part in reproduction he was tolerated around the house as a wage-earner, a star boarder, with very limited privileges. Then the boy was born. The women raised him as a girl, but they had no technique with which to handle his lively, aggressive, boyish tactics. Eventually they resorted to

mere physical prowess. His was a series of castigative experiences, not at all without overt pleasure to him.

He entered the world beyond his own home with only a sado-masochistic equipment. Love and affection were qualities that many of his playmates and schoolmates knew from experience. He had only heard about them. Lovelessness was his pattern, though in later years his friends knew him as a boy and man who loved books and learning. His father, a schoolteacher, lived in the library at home. He, too, was severe, but in a verbal way, for he demanded from his son exactness in studies and long application to them. His philosophy was never to praise the son for work well done, because approbation sired carelessness.

The son left home when he was twenty-two years old. By that time he had a position as teacher and translator. Though his mother did not need it, each week he sent the better part of his salary home to her, not, however, without often receiving complaints from her to the effect that he was stingy.

Up to the age of twenty-four he had never had a love affair, though he had had several "crushes" on older women. When he was nineteen years old he "fell in love" with his father's sister. At twenty he "fell in love" with a woman about fifty years old. They caressed under the sway of his scholarship—so they reasoned. It was the first time he had ever received affection from a woman, virtually a mother surrogate. Scholarship was later supplemented by bodily intimacies that were the equivalent of incest.

He married when he was twenty-four years old and his wife was thirty. Her reason for not having married

sooner was because men were not to be trusted. In short, she was a miniature edition, in point of hostility to men, of his mother. Married life soon became a recapitulation in principle of his mother's home and he came to emulate his father's station as a husband.

The patient had never had a normal boyhood or adolescence or adulthood. He knew only how to be submissive, first to the women of his mother's home, in which he was a physical masochist, so to say, and second to the rest of the world, to which he was a moral masochist.

Through scholastic successes he gained some measure of emotional growth in the sense that he acquired the semblance of an independent ego, one that was not riveted to the steel of the mother. It was difficult, however, for him to accept the plaudits of his professional associates, for he was conditioned to derogation. Indeed, he was hurt by their praise. There are not a few people who become self-condemnatory under the influence of success. It is not judicious modesty; it is pathological masochism, related to the unconscious need for punishment. It is a characteristic of such need to fan out in all directions, to make itself known and felt in all of the individual's activities. Psychologically it is not dissimilar to the compulsion, expressed by some patients, to confess crimes in which they have no part at all, with the object of seeking punishment.

Success was unfortunate for him because it threatened to separate him from his conditioned past. As the years went by, admiration forced itself upon him; he tried to cast it off, gently at first, but when gentleness failed he added sufficient quantities of vigour to keep it in

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abeyance. As his professional achievements increased, marital harmony decreased. He came to hate his wife's adoration of him, though he seldom showed the hate to her. He used to say to himself that if she did not stop liking him he was going to get a stomach ulcer. It was a case of psychosomatic hara-kiri, which finally succeeded in psychological disembowelment, and through which he was unwittingly restored to the position he knew best—masochism.

The foregoing is but a summary of a wealth of facts covering his life history. He eventually managed through insight to loosen the grip of masochism, the bond that kept him tied to motherly women and all that it entailed. With understanding of the dynamic psychological forces within himself, not only did the symptoms disappear but the inimical forces that gave rise to them.

Marriage was his scapegoat, but the animal came back from the wilderness to return to him the "sins" he had tried to get rid of through such a naïve expediency. Psychotherapists refer to this process as a "return of the repressed" (Freud). It is not easy to understand why nature so often forces destructive material out of its secret hiding-place in the unconscious and upon an otherwise innocent and unsuspecting consciousness. Still, that is exactly what happens in many people. In the guise of physical symptoms the fear of death plagues the soldier for years after the harrowing experiences are far behind him and "out of mind." Under the cloak of somatic illness the unfortunate neurotic conceals the mental injuries of the past. It seems strange, in a way, that some people can recall

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only the disagreeable, the hurtful features of their past, as if the impulse to destruction is as vivid as that to construction. Nature makes death a proviso of living. Too frequently man prematurely fulfills the terms of the contract, psychically or physically. A psychosomatic disorder is a form of capitulation to conditions that cannot be solved by wholesome, socialized means. It is often the only or "preferred" method known to the unconscious mind.

The marriage of unusual personalities assumes importance when one or the other or both parties find unhappiness in the union. Many theoretically odd combinations are possible and are actually encountered that do not in any essential way lead to difficulties. A masculine girl marries an effeminate boy, they complement each other, are happy together and give constructively to themselves and others. A boyish man lives in harmony for years with a matronly wife. A wife nurses a hypochondriacal husband for years and both like it. A psychologically impotent husband provides enough otherwise for his wife so that his impotence is only an intellectual fact to them. A highly narcissistic wife gets along well with an equally narcissistic husband.

The significant fact lies not in the type of personalities that marry, not in the inadequacy or immaturity of one or both parties, but in the manner by which the couple adjust themselves to each other. Not a few neurotics get along with relative ease, particularly after they have learned how to manœuvre their neuroses to their best advantage. Indeed, a neurotic may capitalize on his neurosis. This is not said for purposes of establishing validity for anomalous or eccentric per-

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sonalities but to bring out the empirical fact that oddity in and of itself is not necessarily associated with unhappiness of mind or body. Though a married couple may adjust themselves satisfactorily to themselves and their associates, there is always the hazard that their children may not show the same flexibility. Happiness is the keynote of living. It would be far more economical to have it come about spontaneously than to have to spend a lot of time achieving it over circuitous pathways. Although we have long recognized physical disorders that reduce our efficiency as human beings, we are just beginning to inventory the sociological as well as the personal losses attendant upon psychological issues.

What are some of the criteria by which relationship is established between somatic complaints and mental conflicts? Perhaps one of the most telling is the parallelism in time between the two. This cannot always be calculated with temporal accuracy, yet the two are frequently 'enough associated to be of real help in determining cause (mental) and effect (physical).

A husband said that fatigue, restlessness, and a throbbing headache first appeared about a year before he came to the physician's surgery. Then he related the further course of his physical troubles. In later interviews, while going over his personal past life as a human being, he recalled that he had always been tolerant of his wife's requests for money, good clothes, and property commensurate with her ideas until about a year and a half before, when her demand seemed to be excessive to him, though he gave the thought only fleeting attention. But even a passing thought on

that topic had never occurred to him before that time. He noticed also that she was reaching socially toward groups into which he could not hope to move for various reasons. A thought that bothered him most was that she was growing away from him. He was emotionally dépendent upon her and he began quietly to urge her to continue their habitual ways of living. Many times the theme was raised. On each occasion they seemed to drift farther and farther apart. "It made me sick," he explained, "to know that our happiness was being threatened." At the time, he used the word "sick" as a figure of speech, but when the topic was opened for further discussion the word lost its rhetorical value and acquired a real conceptual meaning, namely, that his body felt sick because of the differences he was having with his wife.

The purpose of this brief reference is only to demonstrate how close in point of time a mental and a physical complaint may arise. There is, too, in the foregoing example a clue to the psychological relationship between the dread of his wife growing away from him and the physical manifestations of the dread. It made him sick to think of it. Many patients volunteer the information that if the former marital status were revived, their physical symptoms would be relieved if not cured. Some patients have far better insight of an unconscious nature than we think they have. The unconscious often interpolates decidedly important clues in a narrative, such as the apparently innocent comment: "It made me sick to think of it." The real significance of the keyword "sick" is passed over lightly until its deeper meaning is established. Nothing can be lost, much may be gained

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by assuming that all that a patient says may have bearing on the situation. A good psychiatric technician loses very little time with irrelevant material given by the patient. Yet it is not for the physician to give value to the patient's statements, but to enquire into the issues to determine what emotional merit the patient gives to the subject.

Ideas of importance to an individual are invested with emotions. The scientific name given to this state of ideational activity is cathexis. From the standpoint of treating the patient, how we feel about the concepts expressed by the patient is inconsequential, but how he feels about them is all-important. Psychotherapy is therapy of the emotions—of the patient's emotions, not the physician's. Hence it is often extremely valuable at least to touch upon each topic the patient raises, no matter how insignificant it may seem at first.

Frequently in first or early interviews a patient may give relatively much time to a given theme, but when questioned about it he may promptly wish it dismissed as irrelevant. The degree of resistance may be an excellent indication of a troublesome complex, a complex indicator. It is uncommon for patients, especially during the first several visits to the physician's office, to talk away from the issues bothering them. As a rule what they say should be taken as pointed and notable.

Nobody wants to admit having mental troubles, especially those that they sense are deeply rooted. While this is true regardless of the nature of the unconscious conflict, it is particularly true in the marriage state when social esteem and all that it implies is valued by the partners. The overt breaking up of marriage is

regarded by many as a decisive blow to the ego, but what is more important it is representative of a return to the premarital status of emotional insecurity; it often signalizes a repression to the parental home and all that that means. There are many reasons, sound psychological and sociological reasons, why a partner maintains the marital status even though to do so means the unwitting acquisition of physical disorders of mental origin. It is almost axiomatic that *people whose conscience does not bother them seldom succumb to psychosomatic or other types of neurotic troubles*. Conscience is the prerequisite for a neurosis.

A man, thirty-four years old, married a woman of his own age when both were twenty-eight years old. Both were of high moral standards, though as shall be seen presently he was beset with what he called disgusting impulses. From early boyhood he had "crushes" on boys. To avert any obvious display of the "crushes" he leaned over in the opposite direction, being over-careful in speech and manner with boys. Through adolescence and early maturity his associations were almost exclusively with men, and their relations had all the earmarks of decorum. Yet there was a noticeable trace of refinement in him that made some of his friends think of him as too nice. Some even hinted that he would make a suitable partner for a man. He seldom talked about girls, and, as he said, he listened passively when girls were the topic of conversation. He stated with some shyness that he was very slow to "catch on to dirty jokes," because he simply did not know about women.

When he was nineteen years old he "fell in love"

with a girl cousin. The parents on both sides saw how affected he was in her presence, though he always stood a respectful distance from her. He said he had no ulterior motive concerning her, but since he knew she had many boy friends, he hoped that she might impart her knowledge to him. She did not.

Throughout his college years he roomed with boys, especially with those "whose minds were on their work." He was shy with girls but more shy with boys. He learned how to time his retirement to bed so that he would not have to undress in the presence of his room-mate or be present when the room-mate was preparing for bed. Each came tacitly to know what was expected of the other in the matter of proprieties.

After graduating from college he took a position in a town away from home, setting up an apartment with a man of about his own age. In the interest of economy, psychological, perhaps, as well as financial, he agreed to take care of the household, to do the cleaning, marketing, and cooking. He played the part well, apron and all. Sometimes the occasion was favourable for a gesture or a fleeting comment relative to his efficiency as a housewife. With time these little references became personal and embarrassing, to the degree that the patient searched for a reasonable cause to leave his room-mate.

He did not want to leave his position and go to another town, though he gave much thought to that way of solving the difficulty. He thought the trouble was within himself, that he had voluntarily taken the role of housewife. Maybe, he reasoned, he was perverted, because had he not often felt a peculiar attrac-

tion for his room-mate? An unholy attraction? He went on to believe that if he were homosexual the only solution lay in marriage.

The thought of homosexuality was disgusting and nauseating. In fact, the nausea became real, although by the time it became very disturbing the nausea was dissociated from the idea of homosexuality. It existed as a physical symptom alone and came to be regarded by him as having an organic background. Other symptoms developed; he began to have the sensation of a heavy weight on his chest, a weight that made him breathe heavily in order to get air in his lungs. He felt suffocated.

While he was in this state of illness he retired from all people save one. He had met a girl some time before and she had evinced an interest in him. In his illness he went to her, indicating more by actions than by words that he would like her to be near him. In view of his sickness, so it was rationalized, she took the initiative in their meetings. He was back in the passive role again, but this time it was tolerable because the active member was a girl. She nursed him back to health and soon thereafter they were married.

The intimacies of marriage were carried on always, however, under her initiative. He was not emotionally prepared to share with a woman and he realized, as he said, how unfair it was to her that he went through lovemaking only with his body. He explained to his wife, for he had a need for "complete honesty," that he would not blame her if she sought the warmth of another man. This thought led to the idea that maybe she had had such relations before they were married, for otherwise how was he to account for her facility?

The beginnings of a paranoid syndrome were in the offing by this time and steadily the symptoms moved nearer and nearer to him, until finally he was convinced that his wife was friendly with other men. It happened with him, as it does with other paranoid patients, that men became the object of hostility, the woman being the intermediary between the patient and the men.

At this stage of the development of his delusions old physical symptoms reappeared, symptoms centred around the chest and throat. The physical symptoms gained priority. He was afraid "for some foolish reason" to consult a physician. He said he could not tolerate anyone probing his throat, for it was too sensitive. He gagged when he thought of the examination. He would not see a physician. His refusal was mute testimony to what is called unconscious insight, meaning that deep down in his mind he "knew" that the physician would not find a physical cause and that the symptoms would be ascribed to nervousness and might somehow be looked upon as a part of his total nervousness, including his bitterness toward men.

At a friendly gathering at home he told a guest, a physician, a little of his troubles, enough to lead to the advice that he seek the council of a "nerve" specialist. He went with combined earnestness and reluctance to a psychiatrist, to whom he eventually unfolded his whole story. His paranoid syndrome had not reached a stage of development in which he could not be materially helped. He was very honest and frank in later interviews; his physical symptoms disappeared entirely with the development of his insight into their nature and cause. His position in the world of men and

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women was extensively reviewed and understood by him. He recovered completely, though he is still a "nice, refined man," as his wife expressed it.

Marriage did not cause his illness. The seeds were in him long before he married; indeed, they had taken root and were beginning to sprout when he married.

Any physician, with appropriate understanding, could have helped this man back to health. It is not meant that any physician can benefit all patients who have paranoid symptoms. Psychiatrists cannot do that themselves, when the symptoms are fixed, when the capacity for insight is lacking, when delusions and hallucinations stand out prominently.

It cannot be foretold to what extent a paranoid syndrome may develop, yet it is reasonable to assume that in the early stages of development the patient may be favourably influenced through psychotherapy. Many paranoid patients look to the physician for help, and while they seek assistance the possibility for complete or partial recovery is always present.

The married state is one of the most cogent tests to which the personality can be subjected. In it are impacts from several angles, tests of responsibility, tests of the kind that determine the stability of the entire emotional organization of the individual, tests that pit altruism against egotism. Marriage is a proving-ground over which the individual may travel with ease when the surface is smooth, the curves gentle, and the vehicle in good running order. The track and the machine, however, require adequate construction, frequent inspection, and good maintenance.

XI

THE BODY PROTECTS THE PERSON IN IT

THE mind is but one "organ" of the body. What happens in other organs is felt in the mind. There is much truth in Juvenal's adage *mens sana in corpore sano*, but it may be paraphrased to mean that the body is healthy when organs other than the mind are healthy also. A disease of the pancreas inducing diabetes affects many organs of the body; a disordered heart or liver or lungs or kidneys makes its influences felt in distant organs. The whole body, including the mind, is a mosaic of structure and function.

What has been emphasized thus far is the influence that a sick mind may have upon otherwise healthy tissue. Moreover, discussion has been limited to the milder changes brought about in the functioning of an organ by the influx of an inordinate quantity and quality of emotions to the organ. Heretofore these changes in tissue functioning were referred to as functional disorders, by which term was meant to convey the idea that structural alterations were either absent or undemonstrable. It is quite unlikely that function can change without corresponding structural deviations, but we must await the development of such instruments of precision as may detect alterations that are beyond measurement at present.

It may, however, be recognized today as an empirical fact that emotions can and do invade organs to the point of disturbing their functions to an appreciable

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extent. There is a growing belief, based upon evidence that almost convinces, that not a few structural diseases, such as peptic ulcer, high blood pressure, asthma, hyperthyroidism, coronary occlusion, and many other diseases, are at least aided and abetted by pathological emotions. Research is steadily clearing the way to a better understanding of the emotional features as causative or contributing elements in disease processes. For present purposes, however, we are merely calling attention to this as a high probability, hoping that even in the absence of final proof the treatment of known structural diseases by organic measures may be supplemented by therapy of the emotions. It seems that the question of therapy has to be put conservatively in the present era of medical knowledge because medical men are essentially the outgrowth of physical medicine. That is a simple fact, not intended to patronize anyone, but given merely as a matter of orientation. The history of the growth of medical men has made them physicians in a literal sense, namely, natural philosophers, philosophers of nature in a materialistic meaning, philosophers who have learned to use scientific techniques in the alleviation of human suffering.

Perhaps when we speak of the art of medicine what we really mean is psychotherapy. The art of medicine is as old as the science of medicine, but there has always been the feeling, engendered by the sick and those who treat them, that the personality ills of human beings are best concealed under the cloak of physical misfortune. Even today we knowingly deceive ourselves by giving a physical name to a mental ailment. This way of doing things would not be half so bad if it did not

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prolong the misery of the patient and cause great anxiety to those dear to him. Physicians grew up in that early field called physical medicine, that is, when medicine was largely science, less art. The moment we speak of psychiatrists, a feeling of opposition spontaneously arises and we make some side comment about their being psychic. Again it may be emphasized that the resentfulness is clearly at the expense of some person's health, for most people who are troubled in spirit honestly claim that misery of the emotions greatly transcends that of the body.

In the light of modern medical knowledge it cannot be stated that organic disease is actually caused by emotional disorders. For the moment, this question is in the academic field. But the emotional influences upon disease processes, quite apart from the final etiological factors, are not an academic question. When structural and functional changes reach a point of departure from the physiological range at which they are recognized as pathological and register the pathology upon the mind in the form of symptoms, the mind is promptly set in action. The mind is unquestionably one of the bodily facilities that reacts to all bodily ailments, and it has its own peculiar ways of responding.

The mind may refuse, so to speak, to recognize the existence of pathological anatomy. It seemingly does so, for example, among schizophrenic patients who may experience severe injury or disease without adequately reacting to it mentally. It appears that the mind shuts itself off from the body, looking upon the body as passively as it looks upon the environment. Indeed, many schizophrenic subjects regard their bodies merely

as part of their surroundings. Other individuals, notably those with a deep depression, while acknowledging the presence of their bodies as such, drain off all feelings from the body to the extent that it seems dead to them. Still others, such as those with conversion hysteria, may cut off all mental feelings from one or more organs.

Usually patients who sever emotions from an organ or from tissue in general do not complain to the physician about the absence of feeling. The doctor has to find that out through his examination. The absence of the gag reflex in hysteria is a commonly known example. The shutting off of feelings is a well-authenticated unconscious process that can be demonstrated repeatedly as a post-hypnotic phenomenon. Whole areas of the body can be made anaesthetic through suggestion and it appears that factors in the unconscious can accomplish the same result on the basis of their own spontaneity.

When a body area offends the propriety of the conscience, that body area may cease to exist in the mind of the patient. As a rule patients with hysteria sever the function of the organ that molests the mind, while schizophrenic individuals disjoin both structure and function. That the mind can perform such acts is attested through hypnosis, if such proof is necessary.

The unconscious sector of an hysterical girl protected her against strong incestuous impulses toward her father by separating the genitals almost entirely from her mind. For years her only lover had been her father. He was close to her, though he was free from recognizable incestuous urges. Out of the sense of extreme guilt her genitals ceased to exist for her, though she did relocate

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the feelings formerly connected with the genitals in the region of the stomach. Gastric symptoms were the immediate cause for her seeking medical help.

A young man was helped out of his unconscious dilemma by sexual impotence. The unconscious, however, does not accept the complete rejection of a structure or the function of the structure. It is fooled, as it were, into taking a substitute, because frequently the function of the genitals moves to another area of the body, where it is allowed full and open freedom under two conditions: first, that it may not be recognized for its true meaning, and second, that the misplaced function be regarded as producing troublesome symptoms. Conscience imposes the penalty of sickness for mental "crimes."

The mind may invoke not only anaesthesia, but hypesthesia, of the mental and physical type, in its efforts to gain some sort of solution for its troubled elements. But when it overstimulates an organ in the guise of a psychosomatic syndrome, it can very conveniently do so when that organ is already pathological due to causes not at all connected with the mind. In other words, *the mind may and often does superimpose its own kind of sickness upon an already diseased organ.* This concept constitutes a decidedly important aspect of psychosomatic medicine.

Many people who in the absence of physical illness maintain mental equilibrium under duress, lose the equilibrium when organic disease comes upon them. Disease is a haven of emotional refuge for them, principally because it serves as an excellent rationalizing agency, one that doctors, members of the family, and

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friends recognize as almost a just cause for emotional upset. There is a normal range of emotional disorder as an allowable accompaniment to physical illness, the treatment of which is usually successful with assurance to the patient that he will recover. There is no need for going beyond simple assurance in these instances.

It is not difficult to detect emotional departures that are beyond reasonableness, depending upon the nature and extent of the physical disorder. Not a few patients develop a hysteroid syndrome in association with organic disturbances and though the hysteroid component may seem intense and may even go beyond the period of convalescence from the organic trouble, recovery through assurance is the rule. Many individuals become hysteroid with each physical attack and the hysteroidism seems to act as a blow-off valve for tensions that accumulate in the interval between organic ailments. From the practical point of view it would seem unwise to delve into the underlying factors giving rise to the hysteroidism unless there is reason to believe that further repetition might jeopardize the patient's personal, familial, social, or professional status. The motive in all these various instances is to do as little as necessary, providing it is sufficient. The mind is a storehouse of rich experiences, but it is a storehouse of explosive material also. It is not at all helpful to the patient when the physician acts as the fuse that sets the powder off. The mere fact that there is dynamite in the mind is no reason for inciting it into action.

An organic disease, no matter what its nature, may set free a true mental state. When that is the case it is imperative that the physician institute a measure of

psychotherapy appropriate to meet the needs of the condition. Treatment of the emotional, psychosomatic condition may be begun during the period of the organic illness, depending upon the degree of incapacity occasioned by the organic state. When it is possible to run both forms of therapy concurrently, the one facilitates the other. The earlier the treatment is administered the better, because it frequently happens that the psychosomatic disorder, that is, the mental component, continues long after the organic disease has been cured. The firmer the grip that mental abnormality gets on a patient, the more difficult it is to release it. Treat the patient before conscious control is so weary that it can no longer struggle against the inner peril without heroic intervention. The inimical unconscious is often cowardly; it besets the field of awareness and alertness when the field is sickened by organic disease. Once the unconscious gains a foothold, it is difficult, though not impossible, to dislodge the offending factors.

A twenty-seven-year-old woman suffered from inflammatory rheumatism for a year. She began to recover from the organic disease after approximately three months in a hospital. Subsequent convalescence was steady and uneventful, save for a much slower and less complete recovery from a cardiac involvement. The latter, mitral stenosis, was not disabling, though she was advised against vigorous activity, something in which she had not engaged anyhow for years. Upon her discharge from the hospital and at regular fortnightly intervals she was "followed up" by the physician who treated her. His interests were so converged upon her joints and heart that he overlooked entirely the

fact that her outlook on life was remarkably different from what it had been before the onset of the organic disease. His records showed excellent restoration of mobility of the joints to various tests, but what he did not see, because he did not look for it, was the immobilization of her personality. In fact, from the standpoint of being a human being she was as much incapacitated after the cure of the organic disorder as she had been during it, though the cause of the inadequacy had shifted to a cardiac neurosis.

While in the hospital she thought over the various aspects of her life, placing particular stress upon disappointments. It seemed to her that her life consisted of a series of unsuccessful efforts, terminating, as she saw it, in chronic invalidism. Her childhood, apparently happy while she was living through it, seemed now to have been a series of passive rebuffs, as she expressed it. Her parents appeared to have been kind enough but she never had the opportunity to get close to them. They were too busy. In the hospital she recalled that she was not resentful because of their inattention, but she often yearned to be near them to give affection to and to receive affection from them. They died about a year apart, the mother when the patient was fourteen years old and the father a year later. She well remembered her sadness upon their deaths, because the void that had always been in her heart was then destined always to remain.

From the earliest years of childhood her mother had turned her over to the care of an older sister, who likewise suffered from the absence of parental affection, but who grew to be resentful of her lot in life. The

older sister had to forgo the pleasures of childhood and give precedence to her nursemaid role, and she expressed hostility toward her young sister. The latter was compelled to be the slave of the older sister, who seemed to gain sadistic delight in thus circumventing the assignments imposed upon her by her parents. The patient was an apt pupil in the art of submission. She learned to be her sister's shadow, learned to be her sister.

After graduating from high school she took a position in an office and soon became known for her efficiency. It was not long before she became "boss" for the first time in her life. She was made head of the small clerical force and though she was always literally correct in the management of her subordinates she became known as the tyrant. She was very adept at rationalizing the need for punctiliousness, accuracy, stern attention to duty, and loyalty—the very qualities under which she had been brought up and from which she had secretly hoped to escape. But she did not impose upon others what she herself did not follow. Indeed, her character traits assumed the force of a neurosis; it represented what is known as a *character neurosis*, the symptoms of which are made up of the extreme expression of character traits. With her personality went an excessive and unreasonable need for cleanliness; she was too saving, too penurious.

She was as proud of her office efficiency as the average girl is of dress and attractive manners. It was her so-called attention-getting device, serving the double purpose of placing her at the head of the girls in the office and of providing an effective sublimation for her

sadism. She made capital of her rigid efficiency as some other girls might their comeliness. Her immediate superior was a man of whom she grew very fond, because for the first time in her life she was the object of admiration. She was aware of the fact that the loneliness, created by the parents, was being partially compensated.

With time, however, her boss's admiration shifted from her efficiency to her as a person. She was gravely worried, yet underneath it all happy and proud, when he suggested that her talents were unevenly distributed and he demonstrated what he meant by trying to kiss her. She recoiled as tactfully as she knew how, because she wished not to lose the esteem with which he held her. Eventually she felt that she had to give up her work because of his persistent attentions.

While she was in mild but steady turmoil over the office situation she met another man who took great interest in her by way of her sickness. He noticed that she was unhappy and he had the urge in him to help a girl out of her misery. The urge was sincere; he had no known ulterior design. Although they never became formally engaged they seemed to know that their interest in each other was to culminate in marriage. It could hardly be said they shared interests, because he always took the initiative with her. He wooed her on the basis of amateur psychotherapy. She profited by it in a superficial way, because by constantly claiming that she was getting worse, she received more and more attention, from which she made no move to withdraw. Her appetite for self-immolation was insatiable.

They married when she was twenty-four years old

and continued to maintain essentially the same relationships during marriage that they had before, save that now she began to show resentfulness toward him. It was evident that in her depression, which was more or less constant, she was defiant because he "lorded it over me." She apologized for putting it so strongly, explaining that he was sincerely trying to help her. She did not want him to outline her day's activities, to tell her what clothes to wear, what meals to prepare, what company to invite to the house. Yet she did not take care of any of those details. She could only condemn herself for her ungratefulness to him; the more ungrateful she became the more she blamed herself; it was a peculiar use to which she put self-pity, for it served the dual purpose of deriding her husband and herself. Sadism often hides behind the skirts of self-sacrifice. Those who live with such a person know full well the awfulness of the hostility lurking in sadness.

In her sickness she regained the role of her childhood in that she was at once her little submissive self and also her vindictive sister. Her husband described her as a little girl, comparing her with his sister's daughter who at the age of eight was more stable emotionally than his wife. This characterization of her, however, was given in retrospect, for he had not seen her as a temperamental child before. He said he was blinded by his own efforts to help her.

While she was ill with rheumatism he was extremely solicitous of her. She convalesced satisfactorily from the organic illness but she retained her babyhood under the influence of alleged continuation of the physical illness. This use of disease to perpetuate a mental

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conflict is known by the term *epinosis*, meaning a mental illness secondary to a physical one.

When psy chotherapy was instituted, a situation arose that is not too uncommon, that is, unwitting interference of psychotherapy on the part of the husband. One might have thought that since their courtship and marriage were contingent upon his intense desire to see her emotionally well, he would have welcomed therapy by an experienced and third party. She had made no progress under her husband's inept attempts; in fact, she had become worse, though he did not see that point even after the facts were placed before him. He did not want to see the true state of affairs because if she got well the very reason for having married her would disappear. He needed her as an invalid. When the patient was well on the way to health, well on the way to emotional maturity, the husband became enamoured of a pitiful woman who contemplated suicide because of poverty. The patient brought him back to her through an exacerbation of her mental illness.

Both husband and wife are now getting much out of life through natural channels of activity. They live for each other in terms of present and future happiness, the factors of their past life that held them to morbid ways having been eliminated.

The organic sickness, rheumatism, was an incident in her life, but a very important one because it served to crystallize, to bring to a head, the elements of his and her impoverished emotions which had kept both in misery for years. Accidents, injuries, diseases, particularly those of a transitory nature, cannot as a rule

topple the sound mind save for a short time. But a mild physical injury, otherwise of little consequence, can easily overthrow a weak personality.

Thus far in our discussions emphasis has been placed upon weakness of forces in the sphere of the unconscious. Often in these situations the conscious ego seems to possess sufficient strength to make a fair showing in the environment, because at the expense of emotional immaturity it uses good intellectual equipment to carry the person along.

A common organic set of circumstances that often leads to greater emotional instability than had prevailed before the appearance of the organic state is that connected with pregnancy and childbirth. Pregnancy is always of emotional value to the wife and husband. It always alters the personality to a greater or lesser extent, depending upon the strength of the personality. Although a severe disturbance of organic equilibrium disrupts the emotional harmony of a sound mind, it very seldom gives rise to a prolonged or chronic morbid mental state unless there is prolongation or chronicity also in organic structure and function.

So-called post-partum mental disorders are frequently encountered in women who go through pregnancy and delivery normally from the organic point of view. They are set in motion by the meaning to the patient of pregnancy and childbirth, occurring in individuals whose personalities were fragile long before marriage. Pregnancy and childbirth often constitute true psychosomatic problems from the two principal points of view presented in this communication. In the first place the thought of pregnancy may be the starting-

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point for a whole series of emotional events which culminate in a psychosomatic syndrome. Thinking and feeling comprise an etiologic agent that is usually far more serious in its consequences than injuries or diseases that operate as precipitating causes for the second large group of psychosomatic syndromes.

In the first instance post-partum mental disturbances are post-partum only in the sense that the psychosomatic symptoms appear in bold relief after delivery of the baby. Investigations show that with or without organic complications the groundwork for the mental deviation is laid long before pregnancy, except in those instances in which the organic disorder is obviously so severe that it would disorganize the strongest personality, under which conditions it is hardly fair to refer to the state as psychosomatic. A woman who because of a severe infection or disturbance of her physiology shows a toxic delirium with disorientation, delusions, and hallucinations cannot be said to have a psychosomatic disorder except from the purely academic point of view, because when the organic disease clears up the mind is usually restored to its preclinical state. In these instances there is no reason to believe that the mind could not have stood up well under average conditions connected with pregnancy. Fragile personalities, however, may succumb to the average, physically uncomplicated course of pregnancy and delivery.

A twenty-eight-year-old woman, married two years, wanted to have a baby because she thought a baby would keep her and her husband together. Neither one had ever mentioned to the other the high probability that, if they continued to grow apart as much as they

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had since the first day of marriage, legal separation would be their only solution. The husband did not want her to have a baby because he knew that she was not mentally equipped to love one or even to care for its physical needs. Though she was twenty-six years old when she married, he recognized her as a remarkably naïve girl who was as much a daughter to her parents at that age as she had been in her childhood.

She was intellectually smart and she was pretty. She knew how to dress and she had a body that set off her clothes attractively. Emotionally, however, she was severely handicapped because she was completely dependent upon her parents. Neither she nor they looked upon their relationships as anything but wholesome. None of the three saw anything hazardous in the fact that mother and father conducted almost all the details of the courtship through remote control. The fiancé was taken into the family as a son, a condition under which he silently chafed, since he was marrying, so he reasoned to himself, to move up to a level of independence.

How often people walk right into situations which they are making active preparations to avoid! It is a neurotic trick. A highly religious girl scans the newspapers carefully for items on sin because, as she expresses it, she wishes to test her control over sinful thoughts. The result is that she is more widely read on sin than on religion. And she sees sin where none exists. A young man, morbidly afraid of dying from fright, is completely up to date on all literature directly or remotely relating to the subject. It scares him to think of the topic, yet he searches incessantly for it. A young lady wishing to

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avoid the disaster of marrying a drunkard like her father falls in love with and marries one.

The young couple did not make a judicious inventory of their lives to determine whether their coming marriage could be expected to succeed. Indeed, had they looked somewhat directly at themselves they might have reorganized their lives to meet the requirements of married life.

Arrangements were made to set up a separate apartment. The parents made the arrangements, taking their "children" along as they might have done when the "children" were five years old. The separate apartment was on the same floor on which the parents lived. The young couple married, by document, not by heart. The closeness of married life was quite distasteful to the bride, though she knew, as she said, that everything would turn out successfully; everything always had; the parents saw to that. A child in marriage; two children in marriage. They had kind, solicitous parents.

The onset of pregnancy was a real shock to her, though she tried to conceal the hurt. She did not know why she thought it wrong, yet she could not dispel the feeling that she had betrayed her parents. They had taken the news of her pregnancy with pride "as if they, not I, were having the baby. I felt all alone; their solicitude was not as effective with me as it used to be. I got to feeling that I was having the baby for them; the thought was revolting." She did not appreciate, except intellectually, what she was brooding over. "I was having a baby for my parents," she kept thinking.

She was bewildered through the pregnancy, though

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superficially she maintained the attitude that her parents would see that everything turned out well. The "husband" was a sort of by-product treated with respect and kindness. He wanted to manœuvre his way out of the influence of her parents, but he could not make a move. To all outward appearances they were a happy and natural couple. The obstetrician was pleased with her progress, yet he was concerned with her evident neglect of hygienic measures.

She did not want the baby and she hoped that through some means, not instigated or at least not known to be encouraged by her, the pregnancy might be terminated. When she was little more than half through the pregnancy she suddenly began to be very active in household duties. She had always been passive about such matters, but she explained to her worried parents that since she was a wife and was soon to have a baby she felt the responsibility for knowing how to be a wife and mother. She worked energetically and hopefully—hopeful that overwork might induce an abortion. Often she tried to catch cold, wishing it would lead to pneumonia. She actually wished for it, though to others around the house she pretended to be very cautious about her health. She read and re-read books on the care of the expectant mother.

She developed pneumonia. She had certainly not discouraged it by her fanaticism for fresh air. It did not seem strange to her husband and parents that during the pneumonia she changed back to her gay and light-hearted moods. They did not know why; they did not ask. They concluded that she was her former happy self because she was at rest. They knew the pneumonic

process was not dangerous; the physician had expected good recovery if it did not extend any further. The signs of pneumonia cleared up and she was delivered of a healthy baby; but the symptoms and complaints of pneumonia failed to disappear. She turned the baby over to the complete care of the mother, while she remained an invalid.

From the physical point of view the post-partum period was uneventful, yet the complaints, which she based on the pneumonia, persisted unchanged until about six months after delivery of the baby; then it was recommended that she be seen by a psychiatrist. During the several interviews that took place the foregoing account of her life was obtained from her and psychotherapy was begun. She was quite amenable to psychotherapy, principally, it is believed, for two reasons: first because she had many valuable assets that were put to good service in matters of growth to maturity, and second because she had not repressed her main problems. For years she had known that she was too close to her parents, that she was emotionally aloof to others. Then, too, she was familiar with the outstanding difficulties in marriage. Like the Emperor Jones she heard the tom-toms from their earliest rumblings up to their deafening beats and she felt as secure as he did until the natives pounced upon him.

The obstetrician could have learned all this when he first saw her. Then the therapy would have been relatively easy and she would not have passed through all the misery she suffered. There are many patients who want to tell their woes to the physician, not for conversational but for real, therapeutic purposes. They

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hesitate a little, the physician hesitates more, and a severer sickness is imposed upon a lesser one.

During many illnesses the physician listens carefully to heart action. It is often heard that the patient will recover if the heart does not falter, though the heart is not the seat of the disease. It might often be said also that the patient will recover if the personality stands up well under the ordeal. It is not any more difficult to put the stethoscope to the mind than it is to put it to the heart.

While it seems true that certain types of personality are associated with certain forms of bodily build and that therefore it is often possible to predict the most likely diseases of the mind and body that may befall a given individual, it is not possible to predict the particular form that the mental or physical disorder may assume. The time may come when such correlations will be more accurately established than they are now. To the best of our knowledge today, in spite of the brilliant research work that is being done, it is known empirically that a poorly knitted personality may fail to hold firm when threatened by any one of many different kinds of danger. Thus the young lady whose history was just recounted may have broken down completely in mind if she had had diabetes or myocarditis or encephalitis or any organic disease instead of the pneumonia from which she suffered. A heavy load put on the heart is still a heavy load whether it is due to tuberculosis, arteriosclerosis, obesity, hyper-thyroidism, or another organic disease. Even an otherwise intact heart succumbs to excessive strain; a weak heart fails to function properly under a relatively light load.

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The same general principles hold true in regard to the mind. There is just as much reason for guarding the mind in cases of organic illnesses as there is for guarding, let us say, the heart. It is not at all difficult to test the strength of a personality and to gauge how it may be expected to respond to bodily ailments or to serve environmental stresses.

XII

TYPES OF NEUROTIC PERSONALITIES

THE mind is as accessible to examination as, for instance, the heart is. In many respects it is far more available to study and treatment, because the moods are evident in the gait and posture, in a great variety of movements and grimaces. They are the equivalent of the cyanosis (blueness) of the extremities associated with cardiovascular inefficiency, with the pallor of cardiac collapse, with the coolness of body surfaces. The physician is given multiple clues through ordinary inspection, clues that lead him more or less directly to the source of the trouble.

An important point lies in the consideration that while psychiatrists in their formal, classical examinations perform many tests that seem forbidding to the non-specialist, the tests are little more than an orderly arrangement of correlated observations. There is nothing at all esoteric about them, for the simple reason that they deal with the ordinary facts of behaviour and thinking. Because they are so simple it does not mean that they are less effective in the life of the individual. Indeed, psychiatry achieves much of its value by virtue of the attention it gives to the everyday behaviour of the individual, to the actions and reactions that are so frequently given little or no consideration because they are credited to the events of daily living, as if to imply that the moods and thoughts that steer us through life are unimportant because of their universality and high incidence.

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In a way it is surprising that doctors unfortunately give so little attention in the surgery to the very things that determine the reasons for happiness or unhappiness in the home or in the general daily life of the human being. We fall back upon the simple expediency of attributing moods to one's disposition, letting the problem rest there, though by that attitude we have done nothing more than substitute one term for another. Patients tell us by their facial expressions, by their postures and gestures, by direct or veiled thoughts, what is troubling them.

As we said before, the stethoscope can be put to the mind as well as to the body. In this case the instrument through which is transmitted the healthy, the adventitious, and the abnormal sounds is the mind of the physician. There are certain types of personalities as there are certain types of organs of the body and it is highly desirable that the anatomy and physiology of the personality be understood before attempting to gauge the influence of the human side of the individual upon his organic parts.

In the description of personalities about to be delineated, abnormality is not necessarily implied. Whether a person is an introvert or an extravert is not the important feature but how he gets along with his introversion or extraversion. What it does for him and for others is the significant consideration. Neither is a virtue or a fault in and of itself, though it is a popular belief that introversion is a handicap while extraversion is an asset. These terms merely express the direction of predominant flow of interests of the individual. Introversion means that the emotions are

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largely confined to the subject, are pent up within himself, are little expended upon others. It does not tell whether the emotions are selfishly or altruistically intended or applied. Extraversion means that the emotions are large externalized upon other people or upon things, but again the term does not tell whether selfishness or altruism is the keynote. In other words, it is not the direction of the flow of feelings and interests that takes up our main attention but the degree and quality of the emotions, the uses to which they are put in the service of the human being that gain distinction. Moreover, our current interests converge upon the emotions from the standpoint of their abnormal flow through organs of the body, for that is the core of psychosomatic medicine. The question of personalities is discussed because psychosomatic medicine is a reflection of the interaction of the personality and the body.

THE HYSTEROID PERSONALITY

The term *hysteroid* means resembling hysteria. It denotes, too, that persons who possess this type of personality have an unusually strong inclination to live out their emotions through physical complaints. They meet their own personal needs through vicarious physical activities. It might be said that they gain recognition by way of externalizing their selfishness through physical complaints. At least that is the particular aspect of their personalities that makes them important from the point of view of psychosomatic medicine. Since this is not a textbook in psychiatry

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there are no references herein to those formal psychiatric syndromes commonly observed in mental hospitals or clinics solely devoted to frank mental cases, but rather to those syndromes that are frequently seen in the surgery of the non-specialist in psychiatry and that take the form of "medical diseases."

In the discussion that follows it is not intended to give the impression that the hysteroid personality is restricted to women. It does seem to occur more frequently in them, though it is by no means limited to them. Psychosomatic problems on a hysteroid basis are not rare among psychologically effeminate men, among those men who are identified with both genders.

The hysteroid individual is an odd combination of child and adult. In early childhood she shows an inordinate capacity for absorbing attention through "show-off" methods. She dotes on herself, on her physical activities, on her dress, manners, speech, and the need to excel. She is her own floodlight, though she also basks in that of others. It is characteristic of her, when she meets reverses, to resort to physical complaints in order to maintain her position of superiority. That is exactly what she does in later life when her inner needs cannot be met to her satisfaction. The medical realm is often called upon to establish validity to her claims and too frequently physicians are unwitting conspirators in the plot.

She perpetuates her childhood into and through adolescence, holding firmly to her parents, though she is usually surrounded by friends of both genders. She objectivates her childish ego upon the environment, though she does not share equally with others. Her

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philosophy of living is generally of an adult nature, though it is not supported by her emotions. A cleavage is noticeable between her ideas and her feelings. She invites others to come close to her, yet unless they nourish her ego and keep away from her body she rejects their participation in her life.

She tries incessantly to live on the basis of her ego, but she encounters difficulties all along the route of living because the unconscious forces of nature are always making a bid for recognition. The conflict between conscious and unconscious factors usually ends in a half-hearted and unsubstantial compromise. She possesses all the attributes of femininity, which, when they are about to be called into play, are quickly smothered with a none too subtle masculine hostility. Indeed, this adult-child is both masculine and feminine, yet neither set of traits is fully developed. The failure of development in each sphere is largely due to the fact that *the hysteroid personality does not belong to the individual possessing it*. The personality is a cloak made up of fabrics derived from the parents. She is an admixture of both. On rare occasions when the winds of her inner nature blow the cape open, one gains a fleeting glance at her, before she feverishly draws the garment tightly about her. Her associates urge her to be herself. She tries desperately to be herself, yet she is held securely by the parental net in which she has helped to enmesh herself.

From her early childhood it is recognized that she is an excellent emulator of adults. She is a grandmother or mother throughout the duration of her hysteroid personality. She is commonly known as a little mother, a characterization she cannot shake off in later years.

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Again the odd combination of character traits is seen in that this daughter in late adolescence is an attractive, alluring, well-mannered, radiant girl—cold to the touch. She is an ultra high-frequency apparatus sending out cold heat.

She is relatively at ease with older men or with men of her own age who have a paternal attitude toward her. The mother, her mother, in her stimulates her to seek marriage, which often she would prefer to achieve without courtship. Indeed, she wants a marital state without a husband, a situation that is not at all an impossibility providing she can close her mind to the realities of living as a wife and mother. She lives a life of psychological amnesia, without showing the classical medical symptoms of such. Or she may become amnesic in a truly psychological sense, being unable to recognize her husband and children, while at the same time she is keenly aware of her parents and others. How frequently a husband says: "She doesn't even know I'm around; I'm only the man who supports her!" He adds that she always wants to know where he is, what he is doing, but she is not interested beyond the mere knowledge of his being.

This form of marital existence is not uncommon. Furthermore, it is often the level of adjustment that is maintained throughout marital life, without more than superficial conflicts. Once the partners become used to the bachelorhood of marriage they may even lead a happy existence. Frequently, however, the hysteroid personality longs to be herself, yearns to shake off the parents who invest her. The more firmly she is attached to the vicarious role of play-acting the life of her

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parents, the more difficult it is for her to loosen their grip upon her. When the struggle becomes severe and when neither she nor the parental images within her can come to terms, the unconscious seizes control and often compromises through the formation of a psychosomatic syndrome. It is not entirely true, however, to say that the unconscious forces compromise; they do not for the reason that they gain far more than they give.

The psychosomatic symptoms offer little more than plausibility in the sense that the individual is led to feel that she is afflicted with a real disease. The unconscious impulses run amok, like a peevish child in a tantrum in the nursery, with the parents standing by helplessly. This is not a mere figure of speech; it is real. It is difficult to name another situation that exceeds severe hysteria in the matter of bringing grief, anxiety, and ruin to a family. It is not uncommon to witness an allegedly organically sick person in complete control of a demoralized household, with everyone frantically seeking a solution, each with half-knowledge that the several medical specialists who have been unable to find an organic cause may be tacitly warning them that the problem is rooted in the personality. Yet no one clearly defines his judgment, lest the wrath of the patient fall upon him. The sadism of the hysteroid or hysterical individual is studiously avoided by all, much to the detriment of the patient and others with whom she comes in contact. Physicians do not hesitate to say that the cause of a physical disorder is unclear to them; patients with genuine organic disease are tolerant in the face of obscure conditions, but an hysterical person

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hurls a broadside at any anticipated suggestion that perhaps her mind is the cause of the family misery.

Unfortunately the physician avoids the venom of the hysterical patient, for he has not learned how to prepare an antidote for it. We commiserate with the aggrieved. Sympathy is indoctrinated in us to such an extent that we cannot recognize that emotions can be as deleterious as arsenic.

There is, however, every excellent reason for facing the injuries of the body induced by the mind, facing them with the same impartial scrutiny with which we look into the problems that are truly organic. A patient's emotions are a great deal safer to handle than is the germ of tuberculosis or syphilis; furthermore, good results are very frequently quick to appear, quicker, in fact, than the fruitless search of months and years for organic causes that are not there.

THE NEURASTHENOID PERSONALITY

The neurasthenoid individual is more diffuse in his somatic (bodily) complaints. While his troubles may be centralized in one or two organs or organic systems, there is hardly any part of the body that is not at one time or another the subject of complaint. All the little bodily sensations that are outside the field of awareness in the normal subject are registered by the neurasthenoid person as manifestations of abnormal functioning. He is extremely body-minded, presenting himself to himself and to others as an encyclopedia of pathological phenomena. He is a study in somatic castigation.

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When he awakens in the morning he is extremely tired. He then makes a minute survey of the nature of his activities of the previous day in order to find the cause of his fatigue. He is always certain to find a reason that is satisfactory to him. It may be almost anything: the pie he ate during yesterday's lunch hour did not seem to be well baked; he pondered long over it, was convinced that he should not eat it because nine years ago, on the occasion of his sister's birthday, he ate a piece of pie that looked like this one and he had had a great deal of gas for the next two days. Or he may explain his fatigue by the fact that he had to stand up in the underground all the way home; or the tiredness is due to the shoes he wore yesterday; had he not forgotten, when he changed them, to transfer the inner soles from the older shoes to the newer ones?

The neurasthenoid individual usually has one reason at a time to explain his symptoms, but over a period of a few months or years a great variety of causes may be attributed to the same symptom. For twenty symptoms he may collect two hundred causes. These are derived from various sources, from the food, the body, weather conditions, clothing, the number of quilts he slept under last night, conversation with a fellow worker who was recovering from a cold, carelessness in measuring with his usual minute accuracy the dose of magnesium sulphate he took this morning, or from the fact that he took it at 7.15 instead of his usual time, 7.05. *It is the universality of causes and complaints that helps to characterize the symptoms of the neurasthenic.*

Everything and anything can converge upon his body to produce a symptom. Over a period of years

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the entire environment may bring all its influences—and they are almost always deleterious—to bear upon his physique. Sunshine; rain, temperature, wind, barometric pressure, spring, summer, autumn, winter, the erection of a building next door to his office, the changes in the water supply due to the twenty-minute shut-down of the aeration plant (he had read about it in the newspaper last week). Everything is a source of bodily disruption. These people thrive on masochism, meaning the turning inwardly upon one's self of the sadistic, aggressive component.

They "suffer," too—though they do not suffer as we commonly understand the meaning of that term—from what is called moral masochism, by which expression is meant the unwitting imposition upon one's mind or personality of harmful influences. They hurt their minds as well as their bodies. They never praise their assets; they enlarge upon their liabilities. They stress their bad judgment in all affairs—financial, religious, recreational, professional, marital, and social. They enshroud themselves in feelings of inferiority. One patient keeps away from all social gatherings because he is certain to make unpardonable blunders. Another assigns all social conversation to his wife. A third never makes a purchase, even of the simplest articles, about which mistakes are hardly possible. Still another, highly religious, cannot attend church services because whenever he thinks of praising the Lord, a stronger urge to blaspheme Him crowds out the praise. A neurasthenic is a masochist of a high order.

A neurasthenic, however, is even more than a masochist. For every feeling of inferiority, mental or

physical, there is a corresponding, though very subtle, one of superiority. This is evident in the magical omnipotence which he apologetically ascribes to himself. Though he never brags about his knowledge of all things, he knows the influence on the human body of a drop of ten degrees in temperature and he knows exactly how to counteract the baneful effects; he knows that eight drops, not nine or ten, of a given medicine will produce the desired results; he knows exactly what will happen when he eats a little too much or too little; he knows the effects on the body of changes in barometric pressure, of variations in humidity; he knows the most auspicious occasions for wearing wool or cotton. Indeed, there is untold strength in his weakness, unlimited knowledge in his ignorance.

We physicians do not treat him. We are simply the social agency through which he obsequiously proves the validity of his omnipotence. What an unwholesome way to gain distinction! Yet it is the only way he knows.

Like so many of his colleagues in the field of psychosomatic medicine, he is emotionally enslaved to his past, to his childhood. He superficially subordinates himself to everyone as he did to his parents. It is not a play on words to say that *all the world is a parent to him*, because that is virtually what he conceives it to be. Only the age of the physique is determined chronologically. The age of the person in the body is measured by the emotions. Neurasthenia is merely one of the several means by which childhood is perpetuated into and through the years beyond childhood.

The degree of development of the intellect plays no essential part in the course of neurasthenic childhood.

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The most brilliant intellect may exist side by side with the most conspicuous neurasthenia. Indeed, the strength of intelligence often goes over into the service of neurasthenia and the latter may reciprocate by protecting the intellect from outside hindrances, thus enabling the intellect to build itself up to disproportionate strength. How inconsistent it seems that a "chronic invalid" can achieve great distinction in his chosen field, distinction that is gained only through great effort! Oddly enough, weakness is strength. The mother who slumps in her chair in complete exhaustion, claiming heart failure because her child persists in asking "foolish" questions while she is absorbed in a book, knows all too well the value of sickness, alleged or real.

When neurasthenia has become "second nature" to an individual, there is little known today that can effectively remove it. It is like an inoperable cancer in that it infiltrates the whole personality and is inseparable from it. The best-known form of treatment is prophylaxis. Prevent the child from adapting himself to invalidism by encouraging the emotions in healthy, adult directions. Prevent the parents from abetting debility in the child in order that they may always maintain the child as a child, or in order that they may perpetuate their own neurasthenic childhood through their children. Many children are sacrificed on the altar of parental emotions.

THE PSYCHASTHENOID PERSONALITY

The central phenomenon of the psychasthenoid personality is a fear complex. *All fears are associated with*

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physical symptoms, many of which are due to the frightening influences of external events or objects; *but the fear that gains our more immediate attention is the morbid fear of disease, nosophobia*. This fear commonly has its onset in childhood and is largely engendered by the parents who are apprehensive of contracting disease through external agencies or through supposed weaknesses in their own bodies. Fear of disease is the bond between the child and his parents; later in life it becomes the scapegoat for the unwitting resumption of parental reattachment, particularly among those individuals who either cannot shake off the family ties or who, meeting life situations that are too difficult for them to hurdle, fall back upon the parents or their images through the ruse of physical disease. The process takes place in the unconscious; therefore the patient is unaware of the stratagem as such.

Nosophobia can be and often is as thoroughly incapacitating as a real disease. It can cause one to become a bed patient and it may tax the skills of the physician to a great degree. The phobia, however, is always far in excess of the deep concern ordinarily accompanying a physical disease. Moreover, the patient is absolutely certain that he has a disease, even when all possible tests fail to indicate its presence. If he had pathology to the extent indicated by his complaints and over the long period of time that he says he has had the disease, surely the many examinations would offer up at least the minimum of positive results.

Usually the nosophobe gives himself away, so to speak, through other inconsistencies. How can a patient with an allegedly severe heart disease work out in the

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garden under the hot sun all day long? How can he work vigorously in the shop without obvious physical signs of heart disease? Why does a patient with a presumed gastric ulcer eat voraciously when he is away from home and sparingly at home? A real disease is not mindful of the people around the patient, but nosophobia seems often to rise or fall in the presence or absence of certain people, notably the parents or parent surrogates, or, if the patient is married, the wife. Like a child, his symptoms are worse in the presence of those who are close to him. Why do symptoms get so much worse when the patient is on his way *home* after a hard day's work?

To be sure, his illness is noticeable to those in the office or shop, but there his symptoms are relatively mild and do not interfere in any essential way with his efficiency. On the contrary, he is often complimented for his assiduity; he often works many hours overtime or takes quantities of work home. Why is it, however, that the whole atmosphere of the home changes the moment he enters the door? Do the symptoms recognize changes in locale? No, but they do appreciate the changing milieu. Upon his arrival the home becomes a hospital, the wife becomes a nurse, the children must give up their play and retire to some distant part.

It does not seem strange when we know that the heart or stomach or any other organ can be a severe taskmaster, subjugating the ones nearest and dearest to the patient, while he wears an expression of torture and pities them for the trouble to which his symptoms, not he, put them. It must be said in his favour that he is not a malingerer; this is not any conscious plot to rid

himself of his family. If he were severe and conscienceless he could easily get a legal separation, of which the nosophobe often thinks but seldom initiates. Indeed, he frequently explains that he would not oppose his wife if she sought a divorce on the grounds of illness. Nosophobia can and does give rise to intolerable severity, to mental cruelty. But a mental patient is such in part at least because he has a conscience, an inner conscience, but a peculiarly acting one. It protects what it would destroy. It discards what it would retain. It is righteously diabolical.

This bipolarity is often the cause of great unrest in a family. A wife, declaiming love for her husband, kept him awake night after night for several weeks. She slept many hours during the day. When he came home he had to tidy up the house. That was a reasonable assignment, unreasonably supervised by her. In the interval between audible groans she dictated all the house-cleaning. It used to be a source of discontentment to him that she cared little or nothing about house-keeping and did little, but now she was meticulous in her directions. She called for a cigarette. He took it upstairs to her. Then she called for a match. He took it up to her. She called for an ash try. He took it up to her. All of this, and more, really happened. Mental patients are remarkably ingenious. They can love and hate in the same breath, taking full credit for the former and debiting the latter to sickness. It is as if they said: "I love you, but my illness hates you."

The three main types of personality, the hysteroid, the neurasthenoid, and the psychasthenoid, constitute the psychoneurotic reactions that most frequently give rise

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to psychosomatic syndromes. The full-blown symptomatology has purposely been omitted for three reasons: first, in order to emphasize the need for the recognition of the very early symptoms—it is known that treatment of the character traits that often lead to formal mental disorders prevents the development of such mental disorders, second, early treatment is relatively simple and can be carried out by any physician interested in doing so; third, it is believed that the average physician may not have the time or equipment necessary to handle the severer manifestations of fully developed mental states.

For all practical purposes it is not necessary to have sharp, diagnostic acumen for the understanding and management of preclinical psychoneurotic states. It is highly desirable, however, to know the finer points of differential diagnosis between organic and psychic symptoms. Once that distinction is clear, the vital, the human facts become all important, rather than their arrangement in clinical categories.

The concept *hypochondriasis* is not given a special mention in this communication because hypochondriasis usually is a part of almost all mental groups. It is common in hysteria, neurasthenia, psychasthenia, essential epilepsy, schizophrenia, and manic-depressive disorders. At times it overshadows the type of individual in whom it occurs, under which circumstances the diagnostic term hypochondriasis may be preferred.

XIII

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MENTAL disorders, leaving aside for the moment those that are distinctly associated with organic pathology, generally fall under two principal headings, the *psychoneuroses*, often known by the shorter term *neuroses*, and the *psychoses*. Essentially the same life experiences enter into the construction of the clinical symptoms of each category, but the manner in which they are expressed gives peculiar cast to each.

The principal, so-called psychogenic, psychoses are (1) schizophrenia, subdivided into four types—the simple, the hebephrenic, the catatonic and the paranoid; (2) manic-depressive psychosis, of which there are six subdivisions—manic, depressive, circular, mixed, perplexed, and stuporous; (3) paranoia and paranoid conditions; (4) psychoses with psychopathic personality; (5) psychoses with mental deficiency.

The psychoneuroses are (1) hysteria; (2) psychasthenia or compulsive states; (3) neurasthenia; (4) hypochondriasis; (5) reactive depression; (6) anxiety state; (7) anorexia nervosa.

In the incipient stages of each of the foregoing mental reaction types, differential diagnosis may be difficult, but with further study it becomes clearer and clearer. It may be said in general that in the psychoses the ego is relatively weak in that it succumbs to the forces of the unconscious without putting up as much of a struggle against them as it does in the psychoneuroses. Then, too, perhaps by virtue of the weakness of the ego in the

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psychoses, there is a general relinquishment of environmental activity, often to the degree that all environmental associations are lost. The contents of the psychosis constitute the "environment" of the patient. That is not so, however, in the general run of the psychoneuroses, for the individuals of this group usually retain outside affiliations, though under great stress.

In schizophrenia the ego is weak because it cannot cope with the instinctual drives from the unconscious nor the social drives from without. It is literally crushed between the two, though it finally lets the unconscious forces take over, and when they do there is often, though not always, the proviso that in meeting the environment the unconscious, instinctual urges present themselves in symbolic garb (i.e. delusions, hallucinations). The unconscious is more conventional than is commonly supposed, since it has and usually exercises this capacity to express its urges as appropriately as it knows how for the sake of appearance. To be sure, it does not have custom-tailored clothes, yet the patchwork meets the requirements of decency if not of modernity. From a distance the patchwork looks to be carelessly put together, but on closer inspection it is seen that the cloth is strong and closely woven and that the seams are firm. This is but another way of saying that the delusions and hallucinations that characterize the patient with schizophrenia are a carefully organized entity, derived from the past and therefore antique. It was not so many centuries ago that delusions and hallucinations were the acceptable form of social attire, as can be attested by any student of genetic psychology. The schizophrenic individual is

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simply an old man historically, a senile who cannot keep pace with current progress, who does not know clearly and does not much care that he is wearing crudely made animal skins. It is not the animal man we want to present but the man before he reaches psychological senility. Here we are merely pointing to the weak ego of the schizophrenic as a mark of distinction from his neurotic associates.

Since the psychoses as a group represent an old way of living in a modern environment, it is understandable why psychosomatic problems are so prominent in them. The earliest languages of people were based upon materialistic concepts, of which the body of the human being provided a rich source of somatic expressions. Primitive peoples had no abstract terms or concepts. They employed concrete pictures instead of abstract ideas. Thus the abstract word "five" was represented by the hand. They had no abstract words for character traits, but they used such material designations as thick-skinned, light-minded, firm, soft, pliant, strong. Or they borrowed from atmospheric qualities, using such terms as cheerful, dry, gloomy; or from optic, such as insight, clear-headed; or acoustic, such as discordant; or from tactical qualities, as, for instance, embittered; or gustatory (taste), such as raw; or from thermic states, such as hot-blooded, cold. Psychological antiquity, such as is represented by advanced schizophrenic conditions, is a psychosomatic paradise.

The individual with the shut-in type of personality often falls back on the use of concrete instead of abstract terms. Usually he fails to recognize that he is doing so. He employs the ancient body language, though he

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earnestly believes that his references to the soma or body are indications of genuine bodily disorder. He leads the physician to think that an actual organic condition troubles him, when in truth he is beset by a physical idea which he interprets not as an idea but as a physical reality.

THE SCHIZOID PERSONALITY

The term schizoidism means the state of being split. Therefore, we may think of schizoidism as a type of split personality in the sense that the individual, long before the onset of schizophrenia (formerly called dementia praecox), separates himself to a greater or lesser degree from the environment. There is a distinct breach, wider in some than in others, between the individual and his milieu.

The schizoid child is a soloist. In his infancy he shows the inclination to remain alone. He is the type of infant who can be left in the nursery for hours at a time, during which he amuses himself with simple playthings and with a wealth of imaginings. He is commonly shy and retiring and does not reach out emotionally to children of his age. When he is pressed into activity with others there is a strong urge on his part to withdraw. It cannot be said that his character traits are abnormal unless he is severely retiring, a degree of withdrawal seldom seen in children. It is the perpetuation and perhaps intensification of shut-in-ness that calls our attention to the character traits, for when the child during the first few years of school life confines himself to himself it is not at all unlikely that he may be con-

ditioning himself to a way of living that may eventuate in schizophrenia or some lesser manifestation of it. Quietness is not a liability by any means, though it may develop to the extent of intense unhappiness up to and including schizophrenia.

The child about whom it is said that "still waters run deep" experiences emotions deeply within himself; he presents little external evidence of them. He is the smooth millpond, contrasting sharply with the cycloid personality who is a mountain brook in the springtime. The schizoid child is ordinarily docile and obedient. He is a nice boy. His parents adore him because he is so quiet and yielding. They say they would rather have a dozen of his kind than one like the boy next door who is always romping around, always active and assertive. Their boy clings to them and, unfortunately for all, they like it. It is pitiful that such a high premium is placed upon submission. Parents too frequently dote upon the shut-in child, thus magnifying his schizoidism and drawing him so closely to them that with advancing years he cannot externalize himself upon others. He is the type of boy who can spend most of his hours away from home with people who are like his parents. When and if he should marry it is to the kind of a woman to whom he has been conditioned, the maternal one.

In school, too, he is a son, not just another boy in the classroom. He is punctual in attendance, follows the rules of order literally, and never fails to do his homework carefully. The teacher, like the parents, rewards him for his diligence and obedience. As he progresses through the upper grades or towards puberty, he comes to know that there is a satisfactory substitute for

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emotional display. It is intellectual outlet. The instincts do not press on as greatly before puberty as they do as and following that period of life. Therefore the adulation that comes with scholarship is quite sufficient for the shut-in. He capitalizes on learning and earns the plaudits of adults. He is truly precocious in that scholastic applause is about all that is left for him when the nature in him ceases to take physical means of pleasure.

The schizoid young man is often remarkably unaware of human relations. Even when he learns intellectually how people share feelings the information is so devoid of vitality that it seems not to be a part of his store of knowledge; at least he never applies it to himself. He is prone to develop a philosophy of living into which he puts no feeling; although he may argue fervently in its favour, it is not a living project. He finds it extremely difficult to engage in wholesome, easy conversation, the type in which the average individual indulges for its emotional value. He is the scholar no matter what the setting may be, whether scholastic, social, recreational, or professional.

He gives neither his mind nor his body to others, which is but another way of saying that he is intensely self-contained, narcissistic. When humorous comments are made in his presence he feels that they are disguised criticisms of himself. He comes to feel that all the world converges upon him in an offensive way and he is constantly busy warding off disagreeable references to himself. He is seldom found with a group of boys or, rather, with a gang of kids who are out for the sheer fun of being together and exchanging real or fancied

experiences that are emotionally toned. When he finds himself by accident with such a group he is highly sensitive, for he believes that their loose conversation, particularly that relating to love and sex, is aimed directly at him. *This tendency to blame the other fellow is known as the projection mechanism.*

The projection mechanism achieves its full morbid development in schizophrenic patients. When the process is clearly in evidence, let us say at puberty, in an individual who shows other traits of schizoidism, it is highly desirable that steps be taken to correct the faulty type of thinking. It may well be the forerunner of psychosomatic complaints. The individual who blames others for degrading his mind may soon begin to blame them for inducing physical changes in him. This is particularly true when sensuous feelings come upon him, feelings to which he raises great objections because to him they are gross, crude passions. He disowns them as a part of his thinking or wishing. He knows that they arise within him but he censures others for bringing them out into the open. Since the impulses of nature are unpardonable sins, he eschews traffic with them.

The usual cause for a further splitting from reality and from his own inner impulses is the urge of the latter to express themselves in the environment. He rebels violently from the sexual impulse, feeling that it is unholy. It is, though he does not know why. It is because underneath it all his only love object on the female side has been his mother, on the male side his father. Nature keeps forcing the sexual issue upon his body in spite of the fact that he looks upon it as something apart from him. He tries to set up an impenetrable

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barrier between his mind and body. When he masturbates, which is seldom, he blames his body as if it were something that did not belong to him, something that conspires to debase him. When this stage is reached splitting is an accomplished fact, though there may not yet be any of the morbid symptoms that characterize the full-blown state of schizophrenia.

As the conflict between the ego and the instincts continues to grow, the individual, who by this time is a preclinical patient, begins to close off his mind as completely as possible from his body. The part of the physique that is regarded as most injurious is the genital area, toward which the mind becomes cold and distant. The blindness of the mind to the genitals amounts to psychological castration, which is often complete in so far as the mind is concerned, though the sexual instinct continues to operate in that zone. It receives no co-operation from the mind, only condemnation and fear. Eventually the sexual drive seeks objectivity, with the minimum of help from the mind grudgingly given.

During adolescence the young man makes ineffectual efforts to socialize himself with members of the opposite gender. First he tries to gain their friendship by means of scholastic discussions. He would far prefer the school as his grounds for approach. When that is not available, he continues to meet his girl friend when others are around. He actively avoids situations of privacy because he knows that his mortal enemy, sex, will then be in a position to overwhelm him.

When the young man has reached such a stage of conflict, it is evident that something should be done to

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help him. What has just been described is real ; it is not a way of living that is encountered in books alone. It is a tragic part of human beings, alive, vital, troubled. No time should be lost in trying to understand and assist the patient out of his dilemma. He looks for aid, but too frequently he stands alone in his helplessness. A little enquiry would undoubtedly lead to an opening up of the conflict for examination and treatment. Many a failure in life, psychosomatic included, can be prevented by treating the patient at this stage of his illness.

The conflict between the mind and the body and its reflections in the environment usually eventuate in the delusion that the body is sick, "rotten," decayed, demoralized. The brain is overwhelmed by thoughts of physical deterioration. The patient worries, loses weight, has no appetite, is sleepless, apathetic ; the joy of living is gone. Now the family physician sees him, a pathetic soul who is believed to be suffering from some severe disease. Pulmonary tuberculosis is the first thought. But all tests are negative. Some form of blood disorder, perhaps, but that is ruled out. Or a focus of infection, but that is not detectable. After a variety of opinions and examinations, it is finally agreed, as a rule, that the endocrines are the source of the trouble and multiple endocrine preparations are administered. If, by chance, an endocrine problem is present it may well be benefited by gland therapy, but the general outlook does not change much. If only the physician would enquire into the life of the person, if only he would see the person in the body, if only he could understand that the body is being sapped by the mind, he would have the clue to the real source of the illness and could

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immediately institute effective treatment. Here is a great opportunity for the practice of psychosomatic medicine. It should not be overlooked, for there is nothing more pathetic, more tragic than living on a schizophrenic level. It is no less distressful because the patient eventually leads a painless existence; he is still a human wreck.

By this type of delineation of the schizophrenic patient it is not intended to preclude the possibility of an inferior quality of the patient's body. It is true that the general physical constitution is different from that of the so-called average person in that many of the patients have an asthenic (weak and slender) form of body build. We know that those with an asthenic habitus often show deviations in the autonomic nervous system, in the endocrine glands, and in the degree of development of the circulatory apparatus. We know, but we are also aware of the fact that not all asthenic individuals develop the peculiar psychology known as schizophrenia. It requires a special type of personality and usually a special set of environmental conditions to produce schizophrenia. No matter what the cause of this disorder may be, treatment is obviously incomplete unless it includes the person himself, as a living, vital component of his surroundings, as one who has likes and dislikes, as one who is trying to progress through the world. This is the only attitude by which the most favourable outcome possible may be achieved.

Schizoid persons, while on their way to schizophrenia, exhibit a wide variety of psychosomatic symptoms, referable to almost all parts of the body. The individual, however; usually converges his mental conflict on one

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or two organs, though he also complains of generalized weakness, insomnia, loss of appetite. *It is not the psychosomatic complaint itself but the type of individual in whom it occurs that is all important.* The physical disorders are as truly conversion phenomena in the schizophrenic, as they are, for example, in the hysteric. It is the organization of the personality that is radically different. In the early stages of any mental disorder psychosomatic symptoms serve but one purpose, namely, the concealment of mental conflicts in the body.

While discussion of the technique of psychotherapy is reserved for a later chapter, it is pertinent here to emphasize certain general therapeutic essentials. Since the average schizoid individual shuns the environment so much and therefore comes to know very little about it, particularly in an emotional sense, one must start treatment on a very simple level; the schizoid person is emotionally a child and we must go down to his level if we are to succeed in elevating him to conduct and thought and feeling appropriate to his chronological age. Too often we take it for granted that all children of a given age have about the same emotional equipment and experiences. A little investigation, however, soon dispels that notion. The schizoid person, particularly the one who may be going in the direction of schizophrenia, is honestly seeking the truth when he asks how children are born, whether they are really the product of overeating, whether they are born through the navel. Not a few adult schizoids, perhaps biologically trained, have no idea of the initial steps leading to impregnation. Their ignorance of the topic is appalling, yet they long to know. So it is by no means a waste of time to

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familiarize the schizoid with the general facts. Indeed, so great is the relief afforded that it is worth every moment of the time the physician can spare for the topic.

The schizoid really does not know, as part of his emotional equipment, that it is *not* a sin to think of a *risqué* joke. He lives with the feeling that it is absolutely wrong to think of such "bad" things. To him it is sinful to think ill of someone, or to see movies that are not strictly educational, or to waste one's time playing; it is "bad" to satisfy any appetite, save that of impersonal learning. These and kindred topics should be taken up seriously with the individual, for unless the facts of reality are correctly understood by him, the foundation for his adjustment at the next higher level cannot be laid. *Often we must explain to the twenty-year-old what we commonly have to explain to the five-year-old.* It is the substance of his deviated emotional growth.

Do not be reluctant to ask the schizoid about his attitude towards himself and others. He is ignorant of the position he is supposed to occupy in the social order. He is always at the periphery of group activity, out of hearing distance. He absorbs reality through his special senses (eyes, ears, etc.), but the true state of what he learns goes to his brain, not his mind. It does not become a part of "him." He depersonalizes almost everything before he takes it in. He depersonalizes himself before he gives out. To be sure, he has a philosophy of living, but it is generally so idealistic as to be impractical and impracticable. We must not be hesitant to cure the basis of his faults, namely, his naïve and fantastic concepts of himself and of the people about him.

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We do not expect a child to know, as adults know, how to move among people. Nor should we expect any more from the schizoid when he is first seen by us. We should not, moreover, hope that a single lesson will ensure correct thinking and feeling and acting. Growing up is a tedious process for the best-adjusted individuals. We should not look for more rapid progress in one who is less favourably equipped. The total time given to a schizoid person need not be any greater than that given, for example, to a patient with tuberculosis, but the duration of treatment needs to be spread over a long period, so that each new concept of living may be put to practical application.

Above all, do not press the schizoid into situations of love and affection until he is fully ready to take on the responsibilities inherent in them. Nothing will force the appearance of psychosomatic disorders more quickly than an attempt to compel a child to be an adult lover. Time and again on our history sheets, under the heading of "precipitating causes," is the brief notation, "love affair." Get the schizoid person first to affiliate his emotions with group activity, to share in some common aim—scholastic, recreational, religious, or professional. Externalize his emotions first through relatively impersonal pursuits. He will begin to feel at ease; he will begin to establish confidence in himself when he experiences the pleasure of giving some freedom to his emotions. It is like "blowing off steam"; internal pressure, felt so keenly in the body of the schizoid, is appreciably reduced when the emotions are set free upon social groups.

Once the emotions are out in the environment, upon

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people and things, the patient is prepared to single out some eligible person with whom to share personal feelings. Do not hurry him. Falling in love, even among normal people, is still a matter of trial and error, trial and success. Inasmuch as marriage is the final test of emotional responsibility, it may be ill advised in the management of certain schizoid individuals to see the test carried through. After all, what we are trying to do is to foster happiness. So if it is believed by the schizoid and by you that celibacy is his level of happiness, then let it be so. Some of the most tragic situations are encountered when people marry who are not thoroughly ready to do so.

Although we said that a schizoid is a soloist, that is true only from the standpoint of society. He is not a soloist in regard to his parents. He is a part of them, they are a part of him. Co-operation on the part of the parents must be had if the schizoid is to gain emotional freedom. They may be the greatest single aid in or handicap to successful therapy. They must be encouraged to give the child a natural range of freedom. This may usually be accomplished, in part at least, by seeing that the parents have emotional interests that are not bound to the son in such a way as to curtail him. It is double jeopardy for a parent to rely emotionally upon a weak child.

Throughout this discussion we have always spoken of the male schizoid. That was done merely in the interests of exposition. The same problems face the girl.

We have purposely neglected any references to the symptoms of the fully developed states of schizophrenia in the belief that the general practitioner usually

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prefers to have his schizophrenic patients under the care of a psychiatrist. Finally, it should not be forgotten that the greatest good will be accomplished by prevention rather than by any current method of curative treatment for the well-developed case of schizophrenia.

Fortunes are spent on educating the brain and body, but only a pittance is reserved for the mind, the greatest single cause of sickness. It might very well be an act of wisdom to include a teacher of social and personal growth on the staff of the primary schools. Such a teacher could grow up with the children, be a part of them, and serve in a liaison capacity between the school and the home.

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MENTAL depression is a widespread condition and within a given range is popularly regarded as physiological and natural. That is particularly true when the grief is the result of environmental circumstances, such as the death of a dear one or sharp financial losses or accidents and injuries. Under these circumstances it is believed that the deepest roots of the personality are relatively undisturbed, the shock being confined principally to the conscious ego. There are all grades of disturbances to the mind, and the astute physician is able to recognize the degree to which a given personality has been disrupted. The best clue is to be found in the strength of the personality rather than in that of the external force giving rise to the depression. A carefully evaluated history of the patient's life, past and present, is the ablest guide by which to express an opinion of the treatment necessary and the probable outcome. A judicious survey of the family background should be made, but care should be exercised not to let hereditary factors, as severe as they might be, interfere with appropriate therapy or be the excuse for inadequate treatment.

There are very few downhearted people who do not have an important psychosomatic aspect. Moreover, when the depression is largely the outcome of a poorly organized and fragile past life, it is not at all uncommon for the faulty unconscious, in co-operation with the conscious ego, to place the responsibility for sadness

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upon physical disorders, real or alleged. For months a patient whose troubles are in the mental sphere may believe them to be purely of physical origin. Often the most casual bodily changes are regarded as the cause of a depression. One patient maintained with great persistence that the pimples on his face were undoubtedly the sole cause. He also held the belief that the pimples on parts of the body covered by his clothing were unimportant. But the body is given the most persistent responsibility when internal organs are believed to be affected. The sinuses are especially eligible as scapegoats for the cause of depressions. Sinusitis may be real, often is, yet it is one of the commonest disguises of mental conflicts. A patient, remarkably unstable emotionally, attributed almost everything to his sinuses—his tiredness in the morning, grouchiness at the breakfast table, failure to kiss his wife good-bye when he left for the office, errors in the office, loss of appetite, and so on. According to the best skills of nose specialists, the patient had excellent sinuses, in spite of all the manipulations and sprays that he had had. Within recent months, however, the ulterior role of the sinuses came under suspicion, whereupon efforts were made by the patient to put primary responsibility upon an allegedly deviated nasal septum. It is remarkable to observe the lengths to which an individual will go in order to prove that his body bothers him, when in fact he is doing nothing more than hiding mental trouble behind a presumed organic disease.

Nature exhibited another of her uncanny dexterities when she put man's ego in a physique, for if the ego had to "stand on its own" there would be more chaos than

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prevails under present arrangements. Maybe it is all due to the possibility that the mind of civilized man is the youngest "organ" of his body and therefore needs the coddling and protection of its much stronger associate, the body. The mind runs to the body as a child runs to its mother. The body never says "no" to the mind, particularly when a little additional persuasion is exerted.

In the most outstanding states of depression, namely, in those patients who show what is known as the manic-depressive reaction, the mind is a weakling, not consistently so, but usually at intervals. It does not stand up well under prolonged activity, chiefly because the conscious ego is subordinated to the inner conscience, called the super-ego. Many people are really children with an intellectual veneer of maturity. This is the concept of the manic-depressive patient, who long before he shows morbid symptoms is characterized by emotional swings of a childish nature. He (or she) is said to have a cycloid or cyclothymic mental organization, meaning that his emotions move in a circular course in the sense that they rise to great heights and fall to great depths. Perhaps it would be more appropriate to describe the course of the emotions as excessively wavy.

In earlier chapters we described the evolution of the mind, showing, among other things, that the earliest formation of the mind was a product of the ancestry of the human mind. As such it was largely made up of instincts, of habit patterns phylogenetically as old as man. The next organized layer of the mind is a reflection of the interaction between the infant's mind and, mainly,

his own body. To designate this stage of mental development the term somatoerotic or autoerotic is used. This is the phase of evolution in which the infant's mind is saturated, so to speak, with concepts of his own organs; it is, in fact, the groundwork of psychosomatic medicine; it is the level of growth in which the mind finds solace when environmental conditions are too difficult to manage. Next, the narcissistic phase was delineated as the period of mental growth when the mind begins to assume some autonomy, when it speaks for itself and does not need the body to be its essential mouthpiece. It was shown that the spokesman for the child's mind was really not the child himself but the parents, which was but another way of saying that the training of a child's mind by the parents leads to the indoctrination in the child of parental concepts, of a parental code of behaviour, known scientifically as the super-ego. The super-ego first operates from the level of consciousness but, owing to incessant repetition, it becomes second nature and later carries on its functions from the level of the unconscious. The super-ego is simply the inner conscience, erected through the efforts of the parents. The whole process takes place through the mental mechanism called *identification*, which means that the child has the capacity to learn from others through imitation.

We need not review further what has already been written about subsequent levels of mental growth, because we have reached one of the themes of this chapter, namely, a mental process known as *reaction formation* or *reversal formation*. While the child is learning from the parents how to behave toward himself and

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others, he is more or less constantly faced with the need for covering up old habits with new ones. The simplest way to do that is to relegate the old ones to the field of unawareness, to the unconscious, and to substitute their opposites in overt thinking, acting, and feeling. Thus distinctness is replaced by cleanliness, nudity by clothes, dishonesty by truth, aggression by submission, selfishness by altruism, and so on. The entire process is a reversal through opposites of previous tendencies and is therefore known as reversal formation.

Reversal formation is the way of mental living that is a transitional stage from the narcissism (self-ishness) of infancy to the altruism of maturity. It is never wholly abandoned in normal, healthy individuals, who must often, for instance, act politely when the inner impulse is to hurt, who must stand graciously by while some stuffy performance, for instance, is going on.

There are many people who never move up emotionally to the stage of altruism with any degree of comfort. Their emotions shuttle back and forth between their inner and outer impulses. We commonly recognize them for their emotional instability and they are the ones who are said to have a cycloid or cyclothymic personality. When their variations, their wavy dispositions, are mild they are well within the range of normal, mentally healthy individuals. When the deviations are of such extent as to cause unrest in them and others they are out of the pale of sound mentality. Under the latter circumstances, when the emotions get out of personal control, one of two courses is usually taken: either to divert the emotions to the physique and thus make it appear that the body is sick or to give

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full and free vent to all the inner and outer impulses. The first form of response is the depressive stage of the manic-depressive reaction, the second the manic phase.

It is not our purpose, however, to describe the morbid mental states in their severity but only to go up to them, because the average physician will soon look elsewhere for help when the illness is at its peak. He sees these people perhaps long before any formal psychosis appears; he often treats them for some real or alleged physical disorder; in spite of all his physical skills he watches them grow worse and worse and he is honestly perplexed as to what to do. Out of desperation and in good faith the surgeon removes an ovarian cyst or a fibroid or the appendix. But the symptoms go on unchanged. He washes out the sinuses with no effect on the primary disorder. He treats the gastric "ulcer" medically and surgically or removes a thyroid gland, all without affecting the complaints.

Early identification of the cycloid personality is not difficult. These people have what amounts to an obsession to keep themselves busy. They are always on the go and when one job cannot take up all or almost all of their waking hours they find additional work to do. They exhibit very clearly what is called "flight into reality," in contradistinction to the schizoid who might be said to show "flight into himself." The cycloid person is so incessantly occupied with real conditions, is so busy absorbing the environment that his own inner needs are given scant attention. Indeed, his overabundance of reality constitutes a barrier to the objectivation of his inner impulses. It is a question again of the relative or complete rejection of the need for

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providing natural outlets for the person in the body. It almost appears as if the cycloid vowed that he would never abandon allegiance to his parents; he remains emotionally true to his boyhood and all that it implies. He senses the backwardness of emotional growth in himself and often mourns because he is not free and easy with other people. In his busy workaday life he looks out upon those who are relaxed emotionally, upon those who are sharing their feelings with others, and is saddened to see himself emotionally dammed up.

His friends also know clearly that he is emotionally ascetic, this in spite of the fact that he may be the life of the party, gay, apparently free, lavish in personal contacts. He is emotionally extravagant, however, only under special conditions, namely, that he diffuses his feelings upon a crowd as a kind of protection against intimacy with anyone. It is not at all uncommon for friends and relatives to say, after he has succumbed to a manic-depressive illness, that he is the last person in the world they would have expected to fall ill mentally, for he always seemed to be at ease with people, happy, carefree, talkative, kind and considerate. He was always so communicative. What they did not realize, however, was that his richness of conversation was largely impersonal, that it was derived not from his inner, personal self but from the environment. You can listen to a cycloid person talking for hours; you can admire the breadth of his interests, his facility for remembering dates and events, his enthusiasms, yet when you inventory his encyclopedic knowledge it is intensely surprising how little he *as a human being* appears in the total discussion. You never come to know

him but you like him as an automaton of ideas and feelings.

Sooner or later his inner nature resents the second-hand way in which it is treated. Love and consideration do not always want to reach the environment by way of the intellect or by way of the skeletal musculature. They require personal and intimate contact. They require what the cycloid person is so poorly able to provide.

Cycloidism demands too much energy for its maintenance, because it has to struggle against the strength of nature. The odds for successful evasion against the laws of nature are appreciably against this fictitious way of living. Even when a person manages for years to give precedence to the environment in terms of relatively impersonal acts, he still has to face one of the most critical periods of life, namely, the climacterium, the period of the change of life. Nature usually exacts its pound of flesh at this time of life, if the debt of living has not previously been paid. It is almost an inexorable law. Neglect of the person in the body is punishable by emotional usury.

The cycloid person knows all along that his body is paying dearly for the false overactivity to which it is put. Tensions, sometimes unbearable, are experienced in this or that part of the body. They are due to pent-up emotions, to the real emotions that are almost always relegated to a minor role. Fatigue is a common complaint for which aid is frequently sought from the physician. It is the old story of the tired businessman. We get a clue to the nature of the fatigue when the tired businessman gains some measure of relief by

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adding to his hours of wakefulness the company of female entertainers. It is a form of homoeopathy, combating fatigue with fatigue.

It seems odd that a human dynamo looks to the physician for more and more stimulation; but as he runs faster he tires; as he tires he seeks more energy-producing substances. Unfortunately he frequently resorts to alcohol, which often cannot be expected to exert its medicinal values when the demands are unreasonable. Pharmaceutical houses are kept busy turning out stimulants for the tired man to take by day and sedatives to take by night. Not a few sanatoria gain eminent reputation because, among other things, they provide a regimen of mental and physical hygiene that the person himself, if he knew, or if he were willing to know, could easily have provided through his own efforts. We need laws for various reasons, one of which is to prevent people from squandering their material assets. We need doctors for various reasons, one of which is to prevent people from squandering their emotional assets.

Gastric disorders are not at all uncommon among cycloid individuals, first because these people are so tense and second because they eat as they run. At the table they ingest more business than food. So-called indigestion is the common complaint among them, and when there is indigestion there is disturbance all along the gastrointestinal tract and the organs with which the tract is associated. For instance, gall bladder "disease" is not at all rare among these people. Not a few gall bladders are treated surgically, perhaps justifiably so, because of the carelessness with which

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the person has unwittingly treated his gall bladder, yet abdominal distress is not appreciably relieved by the surgery unless it is accompanied by sensible living, mental and physical, after the operation.

This is not to say that the body is without its part in the causation of bodily distress or disease. There appears to be a vicious cycle in that the cycloid personality is frequently associated with a special type of body build, known scientifically as the pyknic habitus. The body is more or less rounded, due in part to enlarged body cavities, such as the head, chest, and abdomen, and in part to the tendency toward obesity. This extra load, it appears, is often endowed with a disproportionate amount of physical and mental energy. It is not unlikely that there may be as many physical as there are mental factors that contribute to the breakdown of these individuals, yet the kind of life they lead is not by any means an inconsiderable factor.

It appears that the principal fault with the cycloid personality lies in the fact that the inner conscience, that is, the super-ego, the early parental training, operates too sternly against the urges of the instincts and against his conscious wishes. The cycloid person knows full well that though he outwardly appears to be a real part of the environment, he only infrequently obeys his inner impulses. He often asks himself why he cannot be free, why he cannot be himself, and when he is free he is quite apt to condemn himself and to develop feelings of inferiority. He does not know why, though at times he casually explains his self-condemnatory attitude on the basis of his upbringing. He does not sense how close to the truth he is, because if he were to

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understand that his life is being run by his unconscious allegiance to his parents he would not want to believe it lest he be considered an ingrate. It is far less disturbing to his mind to place the responsibility upon diseased or disordered organs of the body.

When a cycloid person marries he continues to be at once both independent and dependent. He is independent in his drive for success in his chosen field of work, earning the praises of his colleagues for his pertinacity, power, and knowledge of his subject. At home, however, he is recognized for his boyishness, which may be shown at times as subservience to his wife, at other times as peevishness, at still other times as hopelessness. He is a moody person, subject to tantrums. Sometimes he is gay, lively, humorous. It is not easy to anticipate his moods.

When he becomes morbidly sick, in addition to showing physical feelings of inadequacy he becomes particularly self-condemnatory, self-pitying. He does not know what grips him so firmly, what keeps him at a standstill, why there is no life, no drive in him. It is not that he is without emotions but that the only emotions he shows are of a depressive nature.

When, however, he enters a manic phase he acts, feels, and thinks, with unlimited freedom. Now he has shaken something off and is free to be himself. But he has gained control over his instincts only in the sense that in some way he has removed the influence of his super-ego, of his earlier training. The instincts find unhampered environmental expression, unrestricted as far as he has or desires to have any control over them. He feels that a great weight has been lifted from him

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and often says that he is free for the first time in his life to be himself. He becomes friendly in a very intimate sort of way with all people. Now, instead of showing his prowess through professional channels, he demonstrates it freely through his physique and he is proud to do so.

The most judicious form of treatment of the cycloid personality is psychotherapy applied before psychosomatic complaints become severe. These people are often seen in the physician's surgery long before they ever get to a manic-depressive state. They are treated for minor bodily troubles that are not known to have physical causation. A little investigation into the personality organization of the patient might very well be rewarded with success. It does not take a seasoned specialist to grasp the meaning of the patient as a human being. It does take care, attention, knowledge of what one is doing, and particularly a desire to know and to help. There is no greater pleasure in medicine for the the patient and for the physician than that associated with the relief or cure of the distressed mind and body. There are no patients more grateful than those with a cycloid personality, who, upon the completion of psychosomatic therapy, experience the freedom of living as themselves, who are no longer the pawn of unseen forces. They are extremely pleased with their new emotional efficiency, which enables them to do their work as capably as they had always done it, but now with the knowledge that they have acquired human economy that leads to relaxation and a natural breadth of emotional interests.

THE EPILEPTOID PERSON

THERE is a type of personality made up of a peculiar set of character traits that stamp the individual apart from others. It was first described in relation to those epileptic patients in whom no definitive organic pathological disturbances have as yet been found. It takes the scientific terms of essential or idiopathic or genuine epilepsy, in contradistinction to symptomatic epilepsy in which there are recognizable organic changes. Genuine epilepsy is an unsolved problem in respect to final cause; however, a great deal is known about its external manifestations and much can be done through treatment to benefit the psychosomatic symptoms, for the reason that the emotions that often seek refuge in organs of the body are modifiable. This means that many of the organic symptoms are removable through psychotherapy.

The symptoms presented by the patient are many and varied. In the absence of a truer knowledge of the final cause for the disorder, no effort is made here to separate the possibly organically based symptoms from those that may stem from the mind. The two, and there seem to be two sources, are so closely united as to make genuine epilepsy seem to be one of the outstanding examples of psychosomatic medicine. The physical symptoms are almost as varied as they are in hysteria, so much so that in former years several eminent authorities suggested that there was a subdivision of genuine epilepsy which they called hysterio-epilepsy.

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For practical purposes of treatment the personality of the genuine epileptic is a real part of the total disorder.

The most common organic symptoms, apart from the epileptiform (convulsive) seizure, which may or may not be seen in association with the epileptoid personality, are a feeling of general body uneasiness, often described by the individual as tension, which may be felt as static or mobile. When the tension appears in the head it is usually a headache, though not infrequently it is "a cloud moving in the interior of the skull." The same sensation may be felt in the chest, abdomen, pelvis, or limbs. Because the symptoms are predominantly on one side of the body it seems that they have organic etiology, but because they are often set in action by the emotions the emotional system seems at least to share responsibility.

Another common complaint is an indescribable but disagreeable taste, which remains with the individual for days at a time. It seems to be almost characteristic of the genuine epileptic patient. It appears probable that this symptom arises from a disorder in the nervous system.

Digestive symptoms are usually observed, including complaints closely resembling those of gastric ulcer. Many of these patients are perpetually on a dietary regimen, which they observe to the minutest detail. In fact, the patient is ordinarily extremely meticulous in following the prescriptions of the physician. In this respect he is not unlike the psychoneurotic patient who is completely obedient to the physician's orders. The epileptic obeys without knowing why, being more alert

than any other type of patient in this incessant search for curative prescriptions.

It should be re-emphasized that we are not referring here to the patient who has epileptiform or convulsive seizures. It may seem strange that there are epileptic patients without epilepsy, if by the latter term we include the convulsive seizure or make it a necessary requirement for diagnosis. There are many other symptoms that fall well within the range of this diagnosis, symptoms that are known as epileptic equivalents. By this we mean symptoms or states of abnormality that take the place of the grand mal or convulsive attack. Many epileptic patients are treated for years for physical complaints and peculiar physical conditions that are variations of genuine epilepsy.

A young man, twenty-three years old, was a brilliant child, a prodigy to those who knew him. He learned with remarkable ease almost anything to which he gave his attention. He read rapidly, studied intently, though never poring over his work. Indeed, he learned so much so quickly that he amazed himself and all who knew him. He was a strong boy, and in physical competition with playmates he was far superior in accomplishment. With no outward display of his mental and physical excellencies, he often went far beyond his teachers.

Toward late childhood he began to suffer from headaches on one side only, not unlike the migrainous type. They occurred quite regularly and were often associated with "indigestion." He was treated at much length for a stomach condition which, however, was never verified by any of the many tests made. During

the stomach attacks he grew faint and on several occasions before and after puberty he fainted. Because the origin of the attacks seemed to him to be due to the high speed at which he lived, treatment was sporadic, if not careless. It was agreed that when he became less tense he would outgrow his troubles, a belief that too frequently fails to materialize. He himself made light of his troubles. The significance of the tension was realized neither by himself nor by his doctors. Even if it is not considered to be a sign of abnormality, physical or mental, nothing can be lost, much may be gained, by closer scrutiny of the factors contributing to the tension.

This boy could have been spared the torture—and torture it was—that he was later to experience for several years. He needed only to be understood as a person, as a human being. Although he participated in sports he never did so for the fun of it. He put all his energies into winning and stopped right there. In fact, when the contest was over, he promptly left the group to conquer new fields. He became a first-rate amateur entomologist with a fine collection of insects that made his home a well-organized museum. He became a philatelist of local renown, again showing his compulsion to collect and organize. Furthermore, he was a well-informed student of the heavenly bodies, and was an editor and illustrator of his own publication in that field. In short, he was a human dynamo, carrying on all these assignments with ease.

He was not a boy among boys. He simply invaded their realms to conquer and then to get out. Over the years of his late childhood and early adolescence he

spent a great part of his time with teachers. Indeed, a little investigation would quickly have revealed the fact that he was a girlish boy. He knew it himself. Underneath the superiorities was the feeling that he was not the equal of other boys. This was well brought out in his first two years of college, when he went in as heavily for alcohol as he had for other pursuits. He had abruptly decided to be the outstanding "he-man" in college, so he "succeeded" in drinking more than any one of his colleagues. He gave himself completely over to the competition with the worst as he had previously done with the best. He could drink more, "stay up longer," curse more vehemently, and tell dirtier stories than all, except one, and to this day he regrets having to take second place to that one. He passed all his college work with commendable grades. In fact, he even tutored a few backward students.

This overcompensation for feelings of inferiority would have been pathetically evident to those who could have looked for them. It is said with compassion that he was at once a sissy and a he-man, but a sissy first. His masculinity was purely fictitious. He never showed it to anyone but his male associates. Girls were anathema to him, though he amused them with his wit and boundless intelligence. He sought their attention for no other reason than to degrade them, though he made a special point never to make it appear so. Indeed, he was so gracious to them that he drew many compliments from them.

Unfortunately the physicians who saw him over a period of several years investigated and treated only the immediate ailment. On one occasion he was treated

for a severe hip injury he suffered while skiing. The physician enquired only into the physical forces that collided. He could have found out that the boy, in a fanatic desire to exhibit his prowess, went down an icy ski jump much against the warnings of seasoned jumpers. Another physician might have found out that the wrist infection for which he was treating the patient was connected with the fact that the young man wrote a letter to a girl with blood taken from his radial artery. A third physician could have determined that the psychology behind a broken thumb was more important than the damaged thumb. The patient insisted upon being the catcher in an impromptu game of baseball. He acted as usual, namely, as though the ball game were the most important event in his life. When he realized that he was just another player he deliberately stuck his thumb out to be hit by an incoming ball. His sense of timing was excellent.

In his third year in college he began to have peculiar attacks ushered in by migrainous headaches that led to the feeling that he was going to lose consciousness. In order to ward off impending loss of consciousness he would suddenly run furiously about his room or, if out in the street, he would run under the pretence of having a natural goal. In his room it had all the earmarks of running amok, for he would feel murderous; he said he had to run in order to get rid of an overpowering tension to destroy. The indoor attack ended when, near exhaustion, he would jump into bed, curl up in as small a manner as possible and act like a helpless baby. The student who went to his assistance described him as being in a state of babyhood.

THE EPILEPTOID PERSON

This state is known as an epileptic equivalent, more specifically as *aura cursoria*, an aimless running about, commonly believed to represent the effort to ward off a grand mal or convulsive seizure. When the patient was finally seen by a psychiatrist the immediate cause for the appearance of the *aura cursoria* was established. The patient said that he had recently fallen in love with a young man of his own age. He tried to prevent the development of the love affair, though recalling that at odd times over the past several years he had felt confident that his happiness could be achieved only through homosexual love. He therefore had entered deliberately into the most ardent love acts with his homosexual partner, "the most exciting, thrilling and freedom-giving part of my whole life." These terminated when he had what very closely resembled a grand mal attack. As this happened before he consulted a psychiatrist, he was immediately put on endocrine therapy. This is not written at all in the nature of criticism. It is said only for purposes of encouraging the physician to add a psychological to his physical investigation.

Eventually the young man was treated by both physical and mental measures. It is pleasant to report that he faced himself as a human being with the same zeal that had always characterized his approach to any subject. It took a fair amount of time to unravel his complexities, but he finally resumed his studies, his symptoms disappeared, and he is a reasonably well-adjusted young man.

Patients of this type are not rare. Although there are many variations of the epileptoid personality, the general nature of the personality is identifiable. The

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make-up of the personality is characterized by the co-existence of opposing traits that are expressed in an extreme manner. Above all, these people are highly selfish and narcissistic, brooking no opposition to their determination to gain their objectives. They ride roughshod over others, yet on occasions they exercise skilful caution lest their ego and drive offend others. Their dictatorial attitude contrasts strongly with their obsequiousness. The extremes are outstanding. One moment in a spirit of compassion they are ready to give away all their property, while the next moment they grasp all within their reach. No one pursues God and Satan with more ardour and less judgment.

They are as meticulous about affairs that do not matter as they are neglectful of those that do. They spend hours or days in doing perfectly something that when finished is without essential merit, all the while being utterly indifferent to some really worthwhile and practical goal.

At one time they love mankind and show it by delving deeply into charitable adventures, often forsaking the ones dependent upon them for a living. At another time they are misanthropes of the first order. One such person founded a home for neglected children. He visited them each week, heavily laden with sweets and toys. It was soon discovered, however, that the children had to be carefully protected while he was with them, because on more than one occasion he beat them mercilessly with his walking-stick after he had given them gifts.

The epileptoid person declaims vehemently for the truth and is ready to go to court over a "white" lie.

THE EPILEPTOID PERSON

While pounding his fists violently in the interest of truthfulness, he often hits the sharp point of falsity which he himself had placed on the table.

Religiously, too, he is an extremist, being a zealot at one moment, an atheist at the next. He is steady in church attendance just as long as he can maintain some position of authority. When he has to give it up he goes to another church, perhaps of an entirely different creed. Then he denounces the first. A patient, married and with several children, shifted from church to church, finally giving all of them up in favour of one he intended to found himself. God had commissioned him to erect this huge edifice in the hilly country of a sparsely settled state, but he worded his declaration in such real terms that it could not be said he was delusional, although the citizens of his community so dubbed him. He took over an abandoned schoolhouse and stocked it with religious literature, obtained by solicitation through the mails. Attendance was meagre because the natives had their own religion and they were not prepared to gain further through reading. He preached daily to amused children.

He set out to gather coins of a certain small denomination and within a few years he had enough money to engage the services of a well-known architectural firm to draw up plans for the real church. While consulting with religious authorities as to his great purpose in life, he was arrested for impairing the morals of a minor. For years he had been a pedophiliac, engaging male children in abnormal sexual practices. Impressed by the inconsistency of his life the court referred him to a psychiatrist. The man had a history of petit mal

attacks of epilepsy, from which he had been suffering for years. He was a childish man, honest, sincere, and gracious while undergoing examination and treatment. He did not remain long enough for a substantial trial by psychotherapy. He relinquished his religious mission in life, subsequently becoming a tradesman.

Apparently it is within the range of a normal personality to possess antithetic character traits, the technical term for which is *ambivalence*. It is not the mere possession or the expression of ambivalence that gives rise to difficulties but rather the expression in extremes of thinking, feeling, and acting. The extremes are associated with bodily tensions, which are often felt as organic disease.

It is entirely reasonable to believe that any physician, suitably familiar with the concepts of personality formation and with a desire to understand and treat patients whose emotions induce morbid physical conditions, can greatly benefit patients. Even if there is a basic, organic premise connected with essential epilepsy and no known successful treatment of the organic anomaly or pathology, psychotherapy can accomplish much in relieving the burden of an oppressed mind and can make far more tolerable the remaining unmodifiable symptoms.

The psychotherapy that can sensibly be carried out by any physician is not basically different in one disorder or another. There is not one form of psychotherapy for each type of personality or for each type of psychosomatic disorder. The mind is alike in general outline for all persons of average or near average intelligence.

XVI

THE CHANGE OF LIFE

THE climacterium or change of life usually covers a few years of unusual events relating to both mental and physical conditions. We commonly think of the involutinal phase from the standpoint of the endocrine glands and their immediate connections, but it is also an epoch in the emotional life of many people. Some pass through this period with a minimum of troubles of either a mental or a physical nature. Others are little influenced mentally though the physical changes may be quite marked. It is a current belief that those who develop the morbid mental state known as *involutinal melancholia* are the ones whose margin of emotional safety was narrow during the years preceding the change of life.

It is known that there are all grades of emotional adaptation, ranging from those who keep well within the bounds of normality up to those who are definitely in the scope of abnormality. We are speaking now of the structure and functioning of the personality long before the involutinal period. Those people, both men and women, who have lived close to the margin of safety are the ones who usually are precipitated into an abnormal mental state at this critical period of life.

Although the single expression *involutinal melancholia* is used to describe all mental disorders occurring at this time of life, it is recognized that many forms of disorder appear depending upon the nature of the personality. The intervention of any physical disease,

whether it is a brain tumour in mid-life, or infantile paralysis, or diabetes at any stage of life, or multiple sclerosis, or cardiac or gastric disease—no matter what the organic changes may be—the intervention acts upon a personality that characterizes the given individual and produces changes that are peculiar to that individual. Thus a brain tumour in a cycloid individual may set free a manic-depressive reaction; it may precipitate schizophrenia in a schizoid individual, hysteria in the hysteroid, psychasthenia in the psychasthenoid. So, too, involutional changes may bring out any one of several reaction types, but because the involutional period is fraught with sadness the different forms of mental disorder of this age may be highly coloured with mental depression.

The mildest form of psychic variation is that known as a *character neurosis*. By this term is meant that the usual character traits of the individual become so pronounced that they acquire the significance of a neurosis, though there are no formal symptoms such as obsessions, compulsions, phobias, delusions, or hallucinations. If the person was inclined to be strict, punctilious, harsh, then those traits may become acutely accentuated during the involutional period. A miser becomes more miserly. A severe judge may become intolerably more stern. When a character neurosis is released by involutional changes it is usual for it to continue more or less unchanged for the duration of life, though a few individuals regain their former status. There is no known form of effective therapy for members of this group as a whole, save that of a palliative nature. It is conceivable, however, that with the improvement

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of organic medical procedures, the lot of the involutional patient may be considerably eased. A far better understanding from the emotional point of view and perhaps also from the physical is taking place now under the influence of shock therapy.

When a hysteroid personality succumbs to involutional changes and develops hysteria, any of the hysterical symptoms observed in earlier periods of life may be seen. Under these circumstances psychosomatic disorders, with or without recognizable physical disease, usually become quite pronounced. They are especially resistive to known forms of psychotherapy, principally, perhaps, because the character traits have been so thoroughly ingrained in the individual over a period of years.

Sometimes schizophrenia is set in motion during this period of life in an individual whose character traits are preponderantly schizoid. To the best of our knowledge today little of a curative nature can be expected from current methods of therapeutic approach in these cases, although some hope may be held out when the schizophrenic symptoms are mild and emotional depression is prominent. It is not at all unlikely that if the patient had been treated for her schizoidism before the onset of the involutional changes, she could have passed through the period with no schizophrenic symptoms at all or with minimum and transitory symptoms.

How can we tell whether a person might experience difficulties in this age period? It cannot be foretold in many instances, yet there is one large group of women in whom potential danger might well be suspected.

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They are the women who show what is called a "housewife's neurosis." Whether married or single, they spend most of their adult activities in the home. The single ones are a sacrifice to their careers and homes. They devote their lives to their parents and brothers and sisters or, if they are schoolteachers, to their scholastic career and home. They give freely to others, expecting little in return.

The wife has a very narrow field of activity. When there are no children she lives almost solely for her husband and home. Occasionally she visits his or her relatives, sometimes they visit friends of long standing, but she has a dread of new things, new people, new places, a kind of real neurotic neophobia. Whenever they do go anywhere it is almost always at the suggestion of the husband.

When there are children in the family, she may get around a little more, but the children are the reason for her wider field of activity. She lives for them, slaves for them, sacrifices for them. She has a housewife's neurosis. This type of person is easily recognized by the physician and he would do well to encourage her to expand her interests beyond the walls of her home. Here is another opportunity for mental hygiene, one that should not be overlooked. It takes so little time and effort to prevent many conditions that give rise to misery in the whole family. There are very few instances of involutional melancholia in which the entire household does not live in distress and turmoil for years on end. This is especially true when the patient was always a loved one because of her thoroughly unselfish nature.

Then, too, there is the husband and father whose

character traits are essentially little different from those of the wife and mother. While it is possible that he may pass through the involutorial period without substantial changes in his character it is probable that he will not.

The emotionally unstable person known as having a cycloid personality is perhaps more prone to involutorial melancholia than others. It may be said at least that he is seen more often in mental hospitals than are persons with other types of personality. Perhaps here we should say "she," because the disorder is more frequent among women.

Some people approach the period of involution with a long history of what might be called miniature attacks of a manic-depressive nature. Their swings of mood, while wide, are still within the range of tolerance. It cannot be said that they are of average emotionality, yet it is only graciousness that keeps them from being thought of as abnormal. The changes attendant upon the involutorial period are often sufficient to precipitate a full-blown state of involutorial melancholia with the most intense symptoms of anxiety, depression, and feelings of great unworthiness, in addition to pronounced physical symptoms, such as loss of weight, absence of desire for food, constipation, fatigue, and marked restlessness.

From both the subjective and objective points of view these patients are usually in painful distress. For the group as a whole, however, the outlook is better than it is in other patients with this diagnosis, because recovery, partial or complete, is the rule, though the illness usually lasts several years. Through the use of electro-shock therapy the duration of the sickness is

very frequently cut short by years. Formal, classical psychotherapeutic methods are generally inapplicable, although psychotherapy by suggestion and persuasion often has a palliative effect.

While involutional melancholia is not generally regarded as a pre-senile state, because many of the patients are well below that period of life, there are still a number of patients who show an involutional-like syndrome very close to the senile stage. Medical research is beginning to appear in a much larger measure than heretofore with respect to the troubles of this age period. It may be hoped that geriatrics will expand noticeably within the near future.

From what has been said about the climateric disturbances, it is obvious that there is no specific form or therapy for the members of this group. There are, however, several procedures that often prove helpful. The first is the maintenance of general physical health through a regular daily schedule of activities. It is highly desirable that sleep be as uninterrupted as possible and that it be encouraged. Warm sedative baths for at least an hour, just before retiring, often prove valuable. The bath may be supplemented by a medicinal sedative, but it is well to keep the latter down to a minimum.

If the patient's condition warrants it, he should be kept occupied at his regular business throughout the day, if possible, or for half-days or some part of the day. Nothing lowers the morale more sharply than idleness in a person who has been accustomed to regular daily activities. If the patient cannot remain at his usual tasks, an effort should be made to get him to enlarge

upon any hobbies he had previously developed or in which he has expressed an interest. It is often difficult to keep these people at work or recreation, but it is by no means impossible in many instances.

The usual handicap to steady occupation at one task or another is the wife (or husband, as the case might be) who, just because she is the wife and because the husband has learned over the years how to manœuvre around her suggestions, may have little influence upon him, other than cause him further to resent her or be antagonistic toward her. A home in which there is a patient with involuntional melancholia may be sweet verbally but thoroughly hellish emotionally. Sadism may be as ubiquitous as the atmosphere. The average patient with this disorder is notoriously stubborn to the kindness of members of the family. When the spouse, too, is charged heavily with aggression, the total situation becomes intolerable. It not frequently happens that the wife may wittingly or unwittingly seize the opportunity to pay him back in kind for all the misery he may have brought upon her over the years. It is due to reactions of this kind, and they can be multiplied many times over, that involuntional melancholia is known to contain as lively a mental component as a physical. Which, if either, may be primary is not known, but which stands out pre-eminently is often decisively known—the mental.

Because of the incessant sadism that may prevail in the household, it may be necessary to have the patient treated elsewhere, perhaps in a nursing home, perhaps in a mental hospital. It is surprising how much a patient tones down when he is with others to whom he

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owes no emotional debt or whom he does not feel free to damn even under the guise of sickness. It may not be without deep psychological significance that the more diabolical a home situation may be, the greater is the difficulty in getting the patient to move from it. He knows where there is peace, he knows where there are experts trained to care for his mental and physical health, yet he will not move an inch toward either. He knows, too, that he is causing a great grief and anxiety to the members of the household ; he openly laments the torture they are suffering, but whenever the suggestion is made that he go away he promptly and vigorously opposes it. He is the type of person who should be certified by the court for admission to a mental hospital, for it is the best place in which he can be appropriately treated.

His diet should be carefully selected, because he is quite apt to neglect his food. Often he is like a baby who must be urged, spoonful by spoonful, to eat. His table manners are frequently most disagreeable, for he not only appears poorly clad at the table but he mopes, pecks at his food, is slovenly and inconsiderate. Perhaps there are few people who would charge such behaviour to organic illness. The sickest patients in a general hospital usually try to be co-operative and clean. The involutional patient who is sloppy at home is usually not that way away from home.

At home the involutional patient bathes with great infrequency. He mumbles that his uncleanness is due to his sickness. There is no reason from the standpoint of physical capacity why he cannot bathe as frequently as was his custom. He shaves at longer intervals than

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was his habit, seldom brushes his teeth, rarely gets his hair cut. It sounds harsh to say that he lives in filth and uncleanness, yet we are familiar with people whose physical health is beyond question, who are happiest when filthy. These are the people who have the compulsion to collect and hold trash, a condition not at all dissimilar to certain patients with involutional melancholia. They never give anything, moral, spiritual, or material, but they have the insatiable urge to receive and retain. They are emotional beggars, and like so many beggars they may be vicious when turned away. Humility and aggression are twins.

The inclination toward filth is considerably lessened when these patients are away from home, partly because of the influence brought upon them by others through their examples of cleanliness, and partly through the patients' own sense of propriety. It really appears as if the patient purposely exudes dirt for its offensive bearing upon one or more members of the household. It is well known that certain psychoneurotic patients, who are sound physically, are absolutely sure that they send off body odours and that these make people miserable. They hold securely to the belief even as they step from a prolonged bath. The dirt comes from the mind, not the body.

XVII

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MENTAL disorders which stem from the mind, that is, which are not associated with organic pathology, may start in either the unconscious or the conscious part of the mind. As an instance of those having their origin in the unconscious, one may mention hysteria based upon an unresolved Oedipus complex. In this case a serene conscious mind may be thrown into great turbulence because of the violent eruption of the unconscious Oedipus forces. The conscious ego, being a master at appeasement, joins with the unconscious, thus making it appear that the two are in harmony, whereas the truth is that the conscious ego is enslaved by the aggressive unconscious.

There is another large group of mental disorders which are initiated by the conscious ego, particularly when the latter is unable to cope successfully with external environmental forces. In these instances the unconscious elements are relatively intact and usually would never get into undue excitation if they were not called upon to support the conscious ego against real or fancied environmental aggression.

Perhaps the simplest example of mental deviations occasioned by the impact of injury upon the conscious ego is the deep grief associated with the death or departure of a loved one. The misery is largely restricted to the field of consciousness. The origin of the distress is well known because it is right out in the open; moreover, because it is known and understood it can usually

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be successfully handled. This is entirely different from the distress caused by factors lying deeply within the personality, that is, in the unconscious. In the latter case the patient has no knowledge of the nature of the inimical forces and therefore can prepare no defence against his stealthy, furtive enemy.

A second simple example of injury to the ego from outside sources is homesickness. When the child who has never been away from his parents for any length of time important to him is separated from them for what is to him a long period, the ego suffers the feeling of abandonment until it can be fortified either by the reappearance of the parents or the presence of others who act in their capacity. Many other examples could be cited to show that anomalous mental conditions may result from ego impoverishment. It is not necessary under such conditions to assume any basic or essential weakness of the inner life. What is needed in these cases is a replacement of the outer emotional source of happiness. This form of replacement constitutes one of the simplest examples of sociotherapy, that is, of psychotherapy by way of environment.

The ego may be so weakened as to be thoroughly unable to effect any conciliation with the environment by its own efforts. Society makes provision for such helpless egos by supporting them in the most expedient way it knows, namely, by giving enough financial aid to ensure sustenance. One way to get such charity is through a frank acknowledgment of indigence.

There is a second means of gaining support by charity without having it appear at all that either charity or a weakened ego is involved, that is, to

“conspire” with the unconscious to produce a psychosomatic illness which will have all the appearances of a genuine organic disease, for which our compensation laws make the employer the source of charity. This is not to say that the patient is fully responsible for the development of a psychosomatic disorder, since that is not true in the vast majority of cases. What is true is that the ego, in its desperate search for maintenance, is repulsed by society until such time as the patient can establish a true and just claim. The unconscious of the patient makes the claim real by setting up what appears to be an organically diseased state. The unconscious seems to do this without the full knowledge or consent of the patient, that is, of his ego. He may sense that something of that sort is going on, but he is in no position to do anything about it.

We are not talking about the malingerer, who is easy to detect today because he cannot well circumvent the technical skills of the medical field. That has been well proven, for example, in the candidate for military service who has tried to escape service by claiming physical or mental illness. He soon finds out that if he had hidden geographically or had employed some ruse such as the claim of being sole support of a family, he might have evaded service at least for a long period of time.

Nor are we speaking of the peacetime malingerer who seeks alms on the claim of some alleged visible defect. He need not at all have a weakened ego. He usually has a clever one which is able to profit through feigned physical inferiority. The law is the best psychotherapist for him, because he is a willing psychopath.

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Malingering does not pay. It is far easier to rob or simply to rest on public charity. Malingering patients seldom consult the psychiatrist, which, however, is not due to his generosity in placing the responsibility on a mental disorder rather than on the patient. However, malingering is frequently diagnosed by the layman, or lawyer, or doctor unfamiliar with psychological medicine.

It may be stated as a generality that wartime psychosomatic problems are not substantially different in cause or appearance from those seen in peacetime. They may arise essentially from (1) the environment, (2) disease or injury, (3) the conscious ego, or (4) unconscious forces. A violent environmental condition, such as the imminence of death at the hands of the enemy, can and often does undermine the strongest personality. Such forces, however, lose their damaging influences upon the mind when the individual is removed from them. Likewise, in an otherwise sound person, recovery from disease or injury is usually followed by restoration of mental equilibrium.

When, however, the mind is originally weak or has but a narrow margin of safety, recovery is ordinarily protracted. Some individuals succumb under the simple preparations attendant upon entering military service, while others begin to fail only under gunfire at the zone of battle.

A man was thirty-two years old when taken into the army. Though he was married and had children he was the type of fellow who had always kept himself so busy with work that he had little familiarity with his family. He was married by document, not love, and his children

were the products of sexual activity, not desire. The family was legally, not emotionally, his. So whenever it appeared that he might have to share some of his time with the family, he had a physical complaint, sometimes fatigue, sometimes aches or pains. Usually, however, he did not have to fall back upon such subterfuges, because he returned home from the office late at night and left home early in the morning. He was the type of extravert who protects himself from the appearance of human, personal qualities. He could not be at ease, save under the duress of work, and that kind of ease is heavily infiltrated with tension.

He had put his heart in work since the first years of college, and just as he was nearing one of the peaks of his ambition he was taken into military service. He looked like a suitable subject for military duty, for he was intelligent and a leader of men. The truth is that he was an intellectual giant and an emotional dwarf. The latter was not seen clearly at the time of his induction. Placing his intellectual ambition above all else, he sincerely hoped he would be rejected. Had he not learned how to manipulate his civil environment and those in it to comply with his needs? He knew he could not do this in the army.

From the first day of contact with military authorities he began to lose his identity, and of course his motive in life was threatened. At least he thought it was, and he worried considerably. He did not know how to get along with people because his facility for ordinary conversation had not been cultivated. The kidding of his comrades only made him feel worse. He began to grow resentful; to himself alone he bitterly criticized

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his superiors, though he could not conceal the postures, gestures, and grimaces that gave evidence of his unfriendliness.

His comrades spoke to him as a human being, not as a business associate and they soon realized that theirs was a language foreign to him. He puzzled them, for they could not understand how a man who looked as if he had been "somebody" could be as he was. A buddy told him the others guessed he was sad, but he answered he had no reason for feeling so.

Just when it appeared that he was about to accept his lot and be friendly about it, his mother began to include little references in her letter to the fact that it was not easy for her to get along on her reduced allowance. He now included her in his worries. Had he not vowed from early boyhood always to maintain her?

He grew morose and over a period of two months he showed fatigue and loss of appetite and sleep of sufficient severity to warrant the attention of the camp psychiatrist. He made three ineffectual attempts at suicide, ineffectual because he "lost courage." Psychiatric treatment, such as could be carried out, was of no avail and eventually he was discharged. He improved rapidly and it was not long before he re-entered his former work.

At no time did it appear that his unconscious was disturbed to the extent that it was influencing his conscious thoughts or feelings. The symptoms seemed to stem largely if not entirely from the sphere of the conscious and could easily be explained on the basis of injury to his ego. The army did all it could to make up his psychological loss, but it could not do so. It is clearly understandable why some might believe that

he was a malingerer. Nevertheless, he had all the symptoms that gave rise to the diagnosis of manic-depressive psychosis of a situational nature, meaning that external factors were believed to be the primary cause. He was discharged from military service not merely because he was unable to continue to perform the duties expected of him but principally because it was considered that if he stayed in service longer he would most likely become an out and out depressive patient of the severer type, controlled by deep abnormal forces within him. Furthermore, it could reliably be predicted that, since he broke down mentally long before he was anywhere near a zone of military combat, he was too great a risk to carry further.

Though the external forces of warfare which operate to set a mental response in action are far more violent than those of peacetime, the final results upon the personality are alike in kind. They differ in degree and in the general type of mental casualties. From the standpoint of hospital statistics, however, the expectation of mental disorders is not much increased, if any, as a result of war. Save for a relatively small percentage, it is believed that the personality that succumbs to a pronounced and formal mental disorder in a wartime setting is the one who would eventually develop a psychiatric disorder in peacetime. Those who are heavily burdened with schizoidism are easy prey for schizophrenia. With some exceptions it does not take much of a social upheaval to change some people from the one state to the other, because they were allergic to society long before they ever put on a military uniform. Likewise there is little reason to believe that the

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true psychoneuroses are caused by the factors of a war-time period. Transient psychosomatic states, representing the ego neuroses, are increased in the line of active battle duty. The public in general and medical practitioners in particular are becoming far more mind conscious than they used to be; they are beginning to appreciate the role of emotions in the causation of somatic disorders. This is true for civilians and soldiers alike. The question is often asked if there is not a growing and steady increase, absolute and relative, in the incidence of mental disorders. The answer is that it cannot be said that there is such an increase except in the medical files. This increase is due, in large part at least, to several factors, such as improvement in the methods of identifying emotional disorders, a better attitude on the part of the public, lay and medical, toward the acceptance of the doctrine that the mind can cause sickness, and a willingness to accept psychotherapy as an effective medical instrument.

We are in a transitional state, much as general medicine and surgery were several decades ago, when the burden of proof rested squarely upon the physician to prove his claims. When he did the public was ready and eager to co-operate. Patients began to prefer the hospital to their own bedroom or kitchen as soon as they found out that the hospital was not a morgue. They feared the early hospitals as they feared, until recently, hospitals for the care of the emotionally ill. While nobody likes to be sick from any cause, there is a growing need for hospitals that are set up for the examination and treatment of those whose emotions are incapacitating them. That need comes from the

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public, encouraged as it is by the steady progress that has taken place in the field of psychiatry, particularly over the past fifty years.

We are learning to look into ourselves with clearer and clearer perspective for the part that we may be playing in the development of mental deviations. There can be no doubt that our surroundings are influential, but we are beginning to disbelieve that, as our forefathers taught, the body is acted upon deleteriously by wrathful gods or by the heavenly bodies or by the earth's magnetic forces or by the telepathic influences of our enemies or by witchcraft. Human nature is giving up its tendency to project its own faults upon other objects, personal and impersonal.

It will be an advanced step when we really come to know the part we ourselves play in the emotional disorders that appear in wartime. This will be true also in peacetime, when we begin correctly to evaluate the several factors involved, for example, in workmen's compensation cases.

A man of thirty-five wished for years to improve his position in life. He had always been an honest, sincere, and steady employee who followed assignments carefully. He displayed little initiative and less ingenuity in moving among people either at work or play. He never complained to others because of his failure to be promoted in work and he was seemingly contented to let the economic status of the industry determine variations in his income. He was looked upon as a fine, upright citizen, which he was. He was economical in the management of his finances, always keeping a "nest egg" for use in an emergency.

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He married when he was twenty-three years old, but not until he had enough money with which to set up a comfortable household. His wife was ambitious, wanted to work at some remunerative position, but he persuaded her to be satisfied as a housewife. He explained that it would not "look good" to his associates if she worked, because it would be a reflection on his ability to support a wife. Generally she tacitly accepted the arrangement, but at times she let it be known that she longed for better things. She was not reaching beyond their means when she asked for replacements in house furnishings, and she chafed when he politely but firmly rejected her interests in such matters. At the same time his sense of littleness plagued him and he became mildly morose.

When in the succeeding years two children came into the family, the added financial responsibilities began to worry him. He did not have the initiative to seek new employment at higher wages, though times were prosperous. Ordinary circumstances at home became less and less tolerable to him, yet his only response to the things that irritated him was to sulk, to become quietly obstinate. He was steadily losing ground as a husband and father.

This was the condition of his emotional life when at the age of thirty-three he was unable to report to work because the day before, while at the machine shop, he bumped his head while straightening up from the stooped position. There was no scalp injury, no symptoms referable to concussion, except perhaps the headache that came on later in the day. He reported to the shop hospital, was thoroughly examined and all tests

were reported negative. He was unable to resume work because the subjective symptoms grew worse. In fact, within a month's time he looked like a very sick man; he was like a patient with catatonia, sad, almost immobile, with a masklike expression; his appetite failed and he lost weight; sleep was fitful.

Through workmen's compensation laws it was decided that the injury was a competent-producing cause of his condition and he was paid a weekly compensation. It was not enough to provide for the family in the little way to which they had been accustomed and therefore his wife obtained employment that increased the family finances over the income that prevailed prior to his illness. Indeed, except for his sickness the family was in a far better condition than it had been for years.

Repeated physical examinations failed to reveal any recognizable organic causative factors. Mental examinations were not enlightening. The circumstances of his life prior to the injury were glossed over as uneventful and noncontributory to the illness, until a year and a half later a psychiatrist who had no interest in the matter of compensation began to treat him as a man who had unwittingly fallen into sickness as a way out of a life situation that baffled him. After six months of psychiatric treatment, twice a week, he recovered; the other members of the family were advised as to how they could share in the over-all improvement of family life.

This was obviously an instance of an ego neurosis in which environmental pressure was too great for the enfeebled ego to govern. Unconscious forces appear to have participated to a minimum extent and there was

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no evidence that any severe damage had occurred in the unconscious part of the mind. Psychotherapy was relatively simple, consisting largely of getting the patient to see and feel clearly the parts that his personality and that of his wife played in his illness. He came to the opinion that it was unfortunate that he had used illness as a solution for what had been to him a difficult life situation.

In the ego neuroses there are many variations of this theme, *the gain through illness*, but in essence they have the same general basis. Much misery could have been spared this family if the members had had the foresight to anticipate the possible pitfalls toward which they were moving. Husband and wife knew they were growing apart but they did nothing to forestall misfortune. It should never have been necessary to call upon medical help.

XVIII

YOUR PART IN PSYCHOTHERAPY

It is not at all easy or comfortable for an individual to unburden himself with respect to his innermost thoughts and feelings. Psychotherapy is by no means a painless procedure. It is often said by those who have experienced it that they would rather have a major surgical operation. And they are right about it. For any individual to lay bare the innumerable personal details of his life is a burdensome task from which he often withdraws. No one is pleased to see himself as he really is. That is one reason why people do not eagerly go to a psychotherapist. As disabling as a psychosomatic disorder may be, it is frequently more tolerable than the awfulness of the personal factors behind it.

He who anticipates going to a physician for purposes of unravelling an intricate and perplexing life should know that the first requirement for successful management of his difficulties is honesty and courage and a resolute determination truly to know himself. It is far easier to recommend this than it is to see it put into practice. The troubled mind engages in all possible subterfuges in order to keep anxieties from overt expression. Mental turmoil is looked upon as a dangerous enemy, which of course it is, and anything that will dull its influences is earnestly accepted. No wonder people fall back upon an alleged physical disease as a defence against the real inimical mental forces! Until the present era of medicine it was their only method of escape and they are not at all to be criticized for

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using—unwittingly, to be sure—the most available means to ward off a worse disaster. Until a better solution was known it seemed more reasonable to have the emotions diverted to the organs of the body than to have them crush the whole person and those dear to him. Fortunately it is no longer necessary to choose either course.

The patient's part in psychotherapy is equally important in its way as is the role of the physician. The person who is looking for help in order to rid himself of a psychosomatic illness participates very actively in the procedure. Indeed, he initiates the treatment, for unless he supplies the physician and himself with ample mental material, that is, with facts and emotions, little of a substantial nature may be expected in the removal of the causes of his sickness. It may not be wrong to say that the person undergoing treatment is his own therapist, although it should be strictly understood that he cannot treat himself without the aid of the professionally trained therapist.

The reasons for that are many. In the first place, since the mind itself constructs the psychosomatic disorder in order to defend the individual from what seems to be a worse fate, it obviously cannot be expected to tear down those defences and thus to expose itself to enemy fire. Particularly is that true when the open part of the mind, that is, the conscious part, is definitely weaker than the closed part. You cannot psychoanalyse yourself and hope for more than superficial gain.

Second, and this is one of the pivotal issues in psychotherapy, there must always be some person to act as the receiver of the ideas and moods that are being

uncovered. It is useless to be a King Midas, for the secret of having ass's ears cannot be covered by one's hair nor be kept from one's barber. The latter, evidently a poor psychotherapist, bursting to tell the secret, whispered it into a hole in the ground, yet later the reeds growing from the filled-in hole kept repeating: "King Midas has ass's ears." When we do not want a thought to bother us, whispering it into the ears of nothingness is of little or no avail. But giving it openly to a professional therapist will remove the conflicting ideas. This way of doing it involves what is technically known as transference. It means that the conflicting set of ideas is lived out upon the therapist as if he were the one for whom it was originally intended. There is a realness in telling others about our troubles. Then we act and feel and think that the one to whom we are relating them is not simply an impartial listener but the real one upon whom we want to express our feelings. Without such transference good psychotherapy cannot be accomplished.

Third, self-analysis minimizes, if it does not preclude, the possibility of the individual recognizing many of the so-called mental mechanisms as they arise. He cannot know himself when he is rationalizing (excusing himself), or projecting (blaming others), or forgetting. But the physician, trained in psychotherapy, can easily recognize these and many other mental tricks.

It is not enough, however, that only the physician identify these subterfuges. The person under treatment must have every bit as much insight into those things as the physician has. That is what makes psychotherapy so distinctive, so different from other medical pro-

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cedures. In no other method of treatment is it so necessary for the patient to be as familiar with each technical detail as the physician. Your physician owes it to you to keep you abreast of these little details and you owe it to him to see that he has ample information upon which to base his opinions.

The person under treatment must be constantly on guard against drawing conclusions too hastily. It is a decisive fault to draw a conclusion before there is sufficient information to make it unqualifiedly valid. In psychotherapy brevity too often defeats the purposes of treatment.

The patient should not use technical words, because in so doing he may fall into the error of bringing to a close a topic that still has much more to be said about it. Technical words have the quality of decisiveness about them. What makes them equally inappropriate in treatment is the fact that they usually reach only the intelligence and not the emotions of the patient. Do not let yourself be led into the trap of facile words and concepts, either by yourself or by your physician. After all, there is nothing in the realm of psychotherapy that cannot be reduced to terms that the man in the street can understand. It is that kind of appreciation of the facts that makes psychotherapy work successfully.

Psychotherapy is a joint procedure with joint responsibilities. You are as much an intimate part of the process as is your physician. To draw careful lines of distinction between the two, is to lose sight of this most important principle. To be sure, each of you is differently equipped. You have the facts and emotions that need to be laid bare; your physician has the

technique for helping you to do so. Before you go to him for psychotherapy you should have your general plan of approach and, in addition, you should know what his is. In what follows, an effort is made to familiarize you with the methods of approach commonly assumed by psychotherapists in the management of the usual psychosomatic disorders uncomplicated by the severer forms of mental deviation.

Psychotherapy comprises a set of procedures, as specific in their way as those associated with the treatment of organic medical and surgical conditions. Variations in the extent and intensity of the clinical disorder under treatment are met by variations in the application of therapeutic measures. Just as no rigid rules can be laid down for the treatment of a gastric ulcer, because each ulcer varies in its own concrete pathology and in the nature of the general physiology of the individual organism in which it occurs, so there is no unwavering systematic course in the management of a psychosomatic disturbance. This simply means that for each clinical disorder or disease the physician plans a general and a specific method of approach, both of which usually have to be changed from time to time, depending upon the course of the disorder, the presence or absence of complications, and the needs of the person who has the trouble.

The first important point is to have a *plan of action*. It is not in the least more difficult to have a general method of approach for the examination and treatment of a psychosomatic problem than it is for those of the well-delineated organic diseases. It is absolutely unnecessary to fall back upon the method of exclusion in

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order to arrive at the diagnosis of a psychosomatic state. This does not mean that differential diagnosis is any less important in psychic matters than it is in organic ones, but it does mean that diagnosis of mental disorders can be reached by direct measures. It is a mistake to end the examination with a battery of negative tests from the organic point of view, with the conclusion that there is no organic disease, meaning by that opinion that "there is nothing wrong with the patient." The patient knows better because he has the symptoms.

The plan of action should include, first, a complete physical examination. This cannot be overemphasized because of its value in differential diagnosis and therapy. It is detrimental to the patient for the physician to be partial to the mind or the body. The essential point being raised here is that when the physician is satisfied that the patient's complaints are not due to organic causes, he should immediately plan to examine the mind or personality of the patient. Under no circumstances should he merely rest with the idea that the trouble is in the mind. He should do something about it.

Personality tests are well within the scope of accomplishment of the average physician. This is not to say that anyone can be an expert psychiatrist and still carry on a general practice or be a specialist in some other branch of medicine at the same time, but it is not asking any more of the physician than is expected of him in medicine. The physician is assumed to know anatomy, but certainly not in the sense that an expert knows it; he is supposed to have a good general knowledge of disease processes, though he may not qualify

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as an expert pathologist. All physicians should be able to recognize abnormal conditions of the heart without the necessity of being a heart specialist; of the lungs, abdomen, and other parts of the body without necessarily being a specialist. In this book no effort has been made to present psychiatry as a specialty but only as an instrument of medicine that can be practised by any physician. Procedures in the identification and treatment of psychiatric issues requiring the attention of an expert have been almost entirely omitted in favour of those which any physician can employ. This is not a gesture of patronage to any physician: it should be recalled that the motive of this book is to provide an added service to that large group of patients who suffer from psychosomatic disorders.

METHODS OF EXAMINATION

After physical causes have been evaluated with respect to the patient's complaints, enquiry should be begun with respect to the person who has the complaints. This is best accomplished by asking the individual to give a detailed account of himself from the time of the onset of his troubles. He will soon know that you are not asking him to repeat his organic complaints, and that you are trying to understand him. Usually he will have to be encouraged to know what you are looking for, with an explanation that people can get sick from the way they feel, from the way life has been developing for them. A thumbnail sketch of another patient's life or a part of it generally helps to get him to talk about himself. You might recount the story of the

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patient who came to the crossroads of life when he could not choose between marriage, which he really desired, or bachelorhood based upon the vow he had made never to marry as long as his mother lived. The more he longed for both the more befuddled he became. He worried about his predicament and the worry began to make him restless; he became shaky and trembly, experienced headaches whenever he tried to make a decision; often he had tremors which he described as butterflies in his stomach. After a few months he lost sight of the fact that the worry over his indecision started the physical troubles and believed that something really organic was at the basis of his physical discomfiture. Because of what seemed to him to be new worries, he no longer had to make a decision between marriage and bachelorhood. The decision was made when the physical illness appeared.

A little story like that may start the patient to thinking about himself. It may not be too relevant to the case at hand, but the general idea may impress the patient. He may say, however, that he felt ungrateful when he left his parents to go to college, because he knew that they were slaving to pay his expenses. He realized that they were getting older and needed his support, though they never intimated as much. While in college, whenever he went out with a girl he felt a pang of remorse; he felt it very keenly in a physical as well as a mental way.

The new patient begins to sense that the mind can cause the body to feel uneasy. He had always known it in a vague sort of way but now it was more than theory, it is something that actually happened to him; he felt

it ; he can almost feel it over again as he remembers the incidents more clearly. When he leaves your office he feels that a burden has been lifted from him, not completely but to a recognizable extent. Before he leaves, you ask him to give more thought to his life. The process of treating the emotions has started, although you are only in the stage of examination. Try not to draw any more than general conclusions during the first several interviews. Let your interest in the patient's story be the incentive for his further elaboration. The great chances are that he will not press you for a decision, because he has the need first to gain emotional outlet and later to understand intellectually the meaning of the events of his life.

The foregoing example may well give us many clues to the nature of the human being under examination. It is a test on human nature, not on a "case," for we are trying to understand not a case but a person who has the "case." Therefore we observe many things as the patient tells his story.

In the first place we note the general way in which he tells his story. We see whether he tells it in a calm, detached way as if he were recounting an incident in the life of another person. If during several successive interviews he recounts events of his life without feeling, we gain some appreciation of the separation of his thoughts from his emotions. We may come to the conclusion that we are faced with a schizoid individual who has emotionally split from his past and who produces only the intellectual part of past experiences. When sufficient information is collected to warrant the belief that the patient is schizoid, our

treatment is different from what it would be if he were, for example, cycloid. The patient provides the material; we make the observations which are tests in every sense of the word.

The patient may relate the incidents as part of a whole series of events, loosely held together by time or by sound association rather than by emotions. He may speak with great feeling, yet if he does not understand the meaning or grasp the significance of what he says, little is gained therapeutically. It is not enough to emote and to talk. It is necessary that the appropriate emotions be expended upon the ideas to which the emotions belong, and in addition to that requirement the patient must have insight into what he says. This is another very important test that is carried out by the physician. The results of the test may vary from time to time and from one group of ideas to another. As a test in the early examination of the patient it is invaluable. A manic or cycloid patient may talk at great length without giving any special emphasis to the many topics he mentions. A phobic may do the same as a sort of guarantee that he may never stop off long enough to appreciate the deeper meaning of what he is talking about. One might say that in both instances the ideas and feelings go right by the ego without giving the latter an opportunity to recognize their value.

A third test represents the ability of the patient to see, however briefly at first, that his physical complaints are probably the consequence of his emotions. In the beginning he may simply allow that such is a possibility because the physician has found it so in his experiences with other patients. It may be a long time, perhaps

even close to the termination of treatment, before he is able to establish relationship between emotions and physique. In some instances it is unnecessary that such relationship be seen, because during treatment emotions may be drawn from an organ or organic system to the personal experiences that gave rise to physical complaints without the patient being intellectually aware of the process. As a rule neither the true hypochondriac nor the neurasthenic nor the schizophrenic is able in any substantial manner to remove the emotions from his points of physical fixation, whereas the patient with conversion hysteria, for example, can eventually do so.

A fourth test involves the wish of the patient to get well. This is not exactly the way to define the wish, for the wish should be founded in the desire to know the causes of the illness. All patients, except, perhaps, well-advanced schizophrenics, wish to get well, but in the early stages of treatment only a few patients are willing to get well at the expense of uncovering their past. It must be remembered that psychotherapy is sharper than the surgeon's scalpel and that unlike the surgeon's scalpel it cuts deeply without benefit of an anaesthetic. If there were some way of removing mental conflicts from a patient without his being consciously aware of it, much time, effort, and shock could be spared. Many have tried to accomplish that through hypnosis, but none have succeeded to date. It is one of the major problems of psychotherapeutic technique to encourage a patient to give up by means of insight the mental conflict that he buried so deeply because he wanted to have nothing at all to do with it. The

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physician should never lose sight of the fact that almost all patients wish to get well, even those who are profiting handsomely through their neurosis, because the latter is at best but a miserable substitute for what they would have if conscious wishing could have its way. One should never tell a patient that he wants to keep his symptoms. As a test, however, as to the possible amenability of the patient to psychotherapy, an appreciation of the wish to get at the mental causes of a neurosis is highly desirable.

A fifth test rests in the ability of the patient to establish confidence in the physician. This means that the patient must show it by living out, abreacting, at least in the physician's presence, but preferably upon the physician as a person, the past experiences which he either did not live out at all, say, upon the father, or which he lived out inadequately. Technically the living out of experiences upon the physician is known as transference. In the process the physician must lose his identity as such to the patient, who acts toward the physician as he would have acted toward his father, mother, brother, sister, wife, or others important to his life. When that happens the physician may be looked upon by the patient as a great benefactor or a mortal enemy, as a lover or an object of hate, but the physician must remember that for successful psychotherapy he is obliged to be the image of those who have been emotionally important to the patient. He should therefore play his role with judicious discernment, for he should never share his emotions as a good or bad father, as a good or bad lover, as a good or bad husband with the patient. Neither the physician's deeply lying emotions

nor those on the surface should appear in a psychotherapeutic session. If they do, it is evidence that the physician's emotions are being treated, and that certainly is not the object of the patient's visit. It surely is not in the therapeutic interest of the patient to beam or to scowl when, for instance, he reviews his masturbatory life or homosexuality or infidelity or his undue love or hate for one or both parents. It is not for the physician to approve or disapprove of the past experiences of the patient, but rather to try to understand with the patient the motive for the experiences in which he engaged. *The object of psychotherapy is to bring original emotions and ideas to the surface so that their true meaning may be understood.* When through such a process they are understood, therapy has been accomplished. The test of transference is one of the most important single tests in the field of psychotherapy. It usually takes several sessions before a fair appreciation of the test is possible.

A sixth test aims to determine the presence or absence of the projection mechanism. When a patient repeatedly throws the responsibility for his troubles upon others and cannot be reasoned out of his delusional position after a thorough review of the facts, it is highly unlikely that the physician, unless he is a specialist in psychotherapy, can accomplish anything with the patient by the "uncovering" method of psychotherapy. Thus little is to be expected by this method in connection with paranoid patients from the standpoint of the general physician. Closely akin to the paranoid syndrome, if they are not a real part of it, are what are called ideas of reference. A patient is said to possess such ideas when

he believes erroneously that people look at him and see all sorts of bad thoughts in his mind; they know from his facial expression or posture or gait that he masturbates; they spit to annoy him; on the streetcar they cover their faces with newspapers to avoid looking at him. Ideas of reference are manifestations of the projection mechanism, and therefore the patients who show them are poor risks therapeutically for the general physician.

A seventh test—it is hardly a test—lies in the consideration that if the patient comes to the physician's surgery not because he spontaneously wants to but because he is doing so under pressure, it is unlikely that the patient will succeed therapeutically. He may be using the doctor's professional skills to prove to the one who insists and/or to himself that he is not sick or abnormal in any way; or with nice words he may challenge your ability to bring about any changes in him, particularly if he needs his neurosis as a defence against, for instance, his wife.

An eighth test comprises a rough estimate of the patient's intelligence. While formal intelligence of an average or better is desirable, the more important type of intelligence is the native form of average or better. High intellectual rating is by no means a guarantee of successful application of psychotherapy. Indeed, it may be a great handicap because the patient may be using his intelligence as a neurotic defence—neurotic intellectualization—submitting all of his past experiences to the intellectual measuring rod.

These, then, are the eight tests in brief: (1) the general approach of the patient to his autobiography; (2) the

ability to face his inner self; (3) the capacity to see the relationship between emotions and physical complaints; (4) the wish to get well; (5) transference; (6) the projection mechanism; (7) examination under duress; (8) intelligence. They are all within the easy reach of examination by any physician.

There are other considerations for the application of psychotherapy. Age is a factor. As a rule formal methods of psychotherapy cannot be effectually carried out with children except by those physicians who have had special training in child psychiatry. Fortunately childhood is a period of relative immunity from mental disorders, though most children are at one time or another a problem to their parents and most parents are a problem to their children. The problems of growing up should not be confused with mental deviations. While it seems true that the groundwork for mental disorder is laid in childhood and that therefore childhood is a period of great importance relative to personality growth, formal mental disorders do not appear as a rule in this period.

The most auspicious period of life for the application of psychotherapy, particularly of the "uncovering" type, extends from puberty to the climacterium. Perhaps the optimum age period is the third decade of life, from the twentieth to the thirtieth year.

From the diagnostic point of view it is the prevailing opinion that patients with a psychoneurotic type of personality are more favourably influenced by psychotherapy than are those with the psychotic type. It would be a mistake, however, to draw too fine a distinction between the two.

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METHODS OF PSYCHOTHERAPY

The object of mental treatment is to remove symptoms and to create or restore harmony between the body and the mind, on the one hand, and between the person and his environment on the other. The basic principle behind psychotherapy comprises a loosening of the emotions from their unnatural and abnormal sites of attachment, such as the heart or stomach, and their relocation upon healthy, constructive environmental interests. It is a characteristic of the emotions that once they become habituated to certain ways of expressing themselves it is difficult for them to advance to new and more progressive methods of adaptation. We are in the habit of saying that this or that person is in a rut. What we really mean is that his emotions are fixed to given patterns of reaction, that they are not free to shift from their old attachments to new ones. A psychosomatic disorder is a kind of compromise in that the emotions move from the mind to the body, thus gaining outlet, but in the disguise of ill-health. Through alleged bodily disease, not only are the pent-up emotions released but they gain a certain measure of respectability when they mimic a physical disease.

Treatment of a psychosomatic disorder consists of four major steps: first, a careful separation of the emotions from the bodily organ under investigation; second, a restoration of those emotions to the original trend of mental interests (mother, father, brother, wife, etc.) from which they sprang; third, full recognition by the patient of the abnormal emotional attachment not only to the body organ but also to the mother or

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father or self, as the case may be ; fourth, the placement of the released emotions in channels of sound environmental issues.

These four operational procedures represent little more in principle than the natural processes of human growth. In the individual who grows up normally, a part of the original emotional energy, first lodged in the tissues of the body, goes over into the service of the mind ; later, both body and mental energy are directed upon the environment in ways that are appropriate to the requirements of the society in which the individual lives.

As practised in the surgery of the physician, psychotherapy is an artificial method of repeating a natural series of steps in the growing up of the emotions. The person seeking the services of the physician for the correction of a psychosomatic disorder knows all too well that when he or she tries to use short cuts, the result is a failure. When a psychosomatic illness is an established fact, the emotions bound to the bodily organ cannot be permanently externalized upon environmental activities without retracing the pathways of normal growth. In other words, it is futile to tell a full-fledged patient to take his mind off his body and put it on work or play. Experience shows that little or nothing is to be gained by trying to divert emotions directly from the emotionally sick organ to the environment. You as the patient know full well that the subterfuge has never worked, though you have tested it hundreds of times. You have changed your job several times without effectively influencing your physical complaints. You have tried to fill in all the

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waking hours of the day with concentrated work. Perhaps you have reduced the hours of work in favour of recreation. Perhaps you have gone on protracted vacations. All of these are futile "treatment" measures, for the simple reason that no matter where you go or what you do, you always have with you, in your mind and body, the chain of circumstances connected with your bodily ailment.

The physician who advises you to go away for a rest fails to appreciate the fact that when you are away you still have within you the causes of your sickness. It is an old-fashioned and ineffectual idea to recommend a vacation in the interest of a psychosomatic illness. Vacations do not vacate a physical complaint of mental origin. Too frequently they accomplish exactly the opposite result, because they provide added opportunity to concentrate upon an illness.

The advice, "forget about it," is even more useless. No one knows better than the patient how utterly helpless he is in efforts to forget something over which he has no control. How can anyone be expected to forget what he does not know, namely, the cause of his troubles? He may momentarily forget the results, that is, the symptoms, but as long as the causes continue to operate, he will be plagued with symptoms.

The "rest" cure and the "forget-about-it" cure are simply devices of evasion, the equivalents of a "do-nothing" attitude toward a disabling illness. Both the patient and the physician who agree to such steps are guilty of negligence.

In so far as experience shows to date, hypnosis, as remarkable as it is academically, does not have very

wide acceptance as a treatment procedure. Psychiatrists sometimes employ it when other methods fail, yet in these instances the favourable results are generally of a transitory nature. The general physician need not feel that he is overlooking an important form of treatment when he neglects hypnosis. Indeed, he may be sparing himself considerable embarrassment.

With respect to psychosomatic ailments there are two active and often effective methods of approach. In point of treatment efficiency the first is sometimes referred to as the "uncovering" form of mental therapy. It is the type of treatment emphasized in this book. It consists of a direct and active interest in the symptoms; it means that the symptoms are traced back to their origin in the mind of the patient, from which point their many ramifications into the life history of the patient are completely studied and treated. By this method the disturbing emotions are handled directly and the connections between the subversive use of the emotions and the organs of the body are clearly established. The truth, intellectual and emotional, sets the patient free.

The uncovering form of treatment is applicable to any individual who has the strength of character to see himself as he is really constituted both on the surface and inwardly. Physicians have the remedy for cure, yet its application may be considerably hampered by the refusal or inability of the patient to co-operate. The results of treatment are no less the responsibility of the patient than they are of the physician.

It is by no means easy on the person to go through with the uncovering form of treatment. Effective psychotherapy may even be more disturbing than the

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psychosomatic ailment is. The cure of the physical symptoms means that the emotional faults of the person are laid bare. Sensing that probability, some patients do not have the strength to follow through to completion. The vast majority of psychoneurotic patients as well as those in the early stages of a psychosis, are amenable to the uncovering type of treatment. It would be an error, however, to choose a form of therapy from the standpoint of diagnosis, for response to treatment, particularly in the incipient phases of an illness, is dependent upon factors that commonly have little diagnostic value. The person who sincerely wants to be helped is the one most likely to succeed.

A second method of psychotherapy, called the "covering up," is sometimes the procedure of choice from the start, though at best it is not believed to be successful when used alone. By this type of handling of a psychosomatic illness, attempts at adjustment to the environment are emphasized. It is the hope of the patient and the physician that if the patient can establish connections with the personal and impersonal environment, the emotions may be drawn from the organs of the body to the external issues about him. This is really a form of draining off emotions from the psychosomatic organ, following the pathways of the uncovering method, but differing from it because the environment is the active treatment agency, and the patient does not have to face his inner self. He comes to know what it means to him to have varied environmental interests and contacts.

In this form of treatment it is usually highly important to have the co-operation of the members of the family,

who are taught to look upon the patient as a growing child (though he may be an adult) who needs their encouragement and example in his efforts to outgrow his dependence upon them. It frequently happens that a psychosomatic patient is unwittingly kept in the dependent role by over-solicitous parents; when that is a factor, the parents are usually willing to change their habits in favour of the patient. The patient himself may be playing the predominant role in maintaining the too-close relationship. When the covering-up form of treatment is used, it is well to keep in mind the desirability of soliciting the assistance of the members of the family in the treatment of the patient.

Generally it is advisable to combine the two methods of psychotherapy, especially with those patients who find it difficult to get along with people. This is especially true among potential psychotic individuals, who usually are lacking in easy, informal contacts with others. An important general distinction to be made between the psychoneurotic and the psychotic patient lies in the consideration that the former usually has some sound attachments to the environment, while the latter is restrained in almost all his activities. That is why in the potentially psychotic individual sociotherapy (covering-up treatment) is often of great consequence.

Psychotherapy is a real, vital means of favourably influencing many of the problems encountered in the practice of psychosomatic medicine. Its principles and practices can be as readily grasped by the lay person as they can by the physician. In fact, psychotherapy is a form of treatment that gives best results when both

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the patient and the physician are more or less equally familiar with the techniques of treatment, as well as with the many vicarious ways by which emotional conflicts can be expressed.

The person who knows current concepts of the interrelationship of the mind and the body is prepared, as well as he can be, to ward off or to lessen the intensity of a mental disorder. It is as valuable to be acquainted with the principles of mental hygiene as it is to know those of physical hygiene. The judicious application of the former can reduce to an appreciable extent the frequency of physical ailments arising from the mind. The lay person can help himself considerably by understanding himself scientifically; by so doing he facilitates the cure of his psychosomatic problems as the cure is applied by the physician.

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